REPORT OF COMMITTEE FOR CREATION OF PUBLIC HEALTH CADRE AND RE- ORGANISATION OF DEPARTMENT OF HEALTH AND FAMILY WELFARE SERVICES

Committee

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Acknowledgement

We thank the Secretary to Government, Department of Health & Family Welfare, the Commissioner, Health & Family Welfare Services and the Project Administrator KHSDRP., for giving us an opportunity for recommending the reorganization of the Dept. of H&FW to include formation of the Public Health Cadre/wing, with a view to strengthen health care delivery system in the State. We also thank the Director, Department of Health & Family Welfare Services, the Director-SIHFW, the Project Director- RCH, Officers from Corporations of Bangalore City and Hubli-Dharwad; and all other Officers and the Field Staff from the Department of Health & Family Welfare, for their active, valuable participation in providing their views and suggestions towards the formation of the Public Health Cadre in the Dept. of H&FW, Govt. of Karnataka.

We also thank the Director, KILPAR, Bangalore, Officers from Suvarna Arogya Suraksha Trust, Bangalore, for their views and discussions. We thank Director, IIPH-Hyderabad for sparing the services of their faculty, Dr Giridhar Babu, as a member of this committee. We also render our thanks to all those who directly and indirectly helped us in all our efforts during this journey. The Committee accolades the support and coordination provided by the Deputy Director, OD of KHSDRP.

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1. Background

Public Health is the science and art of promoting Health, preventing diseases and prolonging life through organized efforts of Society. The field of Public Health encompasses managing programmes and emphasizing prevention and cure while addressing health needs of the population as a whole. Public health contains the broad paradigms of disease prevention and health promotion. Preventive efforts aim at reducing the burden of diseases, preventing premature death and disability in the population. Health promotion efforts involve enabling healthy life styles among the population and helping to create supportive environment for health in the communities.

By virtue of Mysore state Public Health Act, Public health department of Karnataka was renowned as one of the best in the country. Training centre at Ramanagar attracted Medical Officers from all over the country including representatives from World Health Organization and other international agencies, as the preferred centre for field training. An efficient Public health organization is an indicator of progressive society. The Government has obligation to meet the Public health needs of the community. However, it is unfortunate that public Health system has been neglected over the past decades, especially after reorganization of the State. At this juncture, Mysore Public Health Act, 1936 is almost seven decades old and needs to be rechristened as Karnataka Public Health Act 2011. The time is ripe to reclaim the erstwhile public health glory in the state. The Department of Health & Family Welfare is committed to create history by reorganizing the department of Health and Family Welfare Services. This report represents the commitment of the State to provide efficient public health services for achieving better health status of the citizens of Karnataka.

In keeping with the tradition and with the objective of reviving the glory of the Public health system in state of Karnataka, it is the right time that Public health cadre is created.

Earlier it was felt that there was relatively low level of public confidence in public sector health services. However, in the recently commissioned social audit by the Planning department, it has been clearly pronounced that public confidence is better particularly for primary health centers. Hitherto, lack of credibility of services was quoted as main factor for adversely affecting the functioning of all programmes. This problem has been compounded by the lack of training in Public health to various officials in the department of health & family welfare services. Underlying reasons for implementation gaps need to be understood and addressed. According to State Health Policy-2001, Karnataka state is committed to address emerging issues in public health, to strengthen health infrastructure and to develop public health human resources. Also as per the state health policy-2001, Karnataka state recognizes that Research, and the spirit of enquiry upon which it is based, provides the critical questioning and thinking required in the quest for new solutions to old and new problems.

2. The Rationale

There is a strong need for creation of Public Health Directorate and Public health cadre in the state. A Public health professional, has to function as a multi-dimensional manager. His ambit of work includes, protecting, promoting, restoring, maintaining and improving health of people through collective and social action; Managing programmes, emphasizing prevention and cure; addressing health needs of the population as a whole. Reducing the burden of disease, premature death and disease produced discomfort and disability in the population, promoting healthy life styles among the population and helping to create supportive environment for health in communities.

The need for Re-organization of the department

a. To improve the quality of delivery of healthcare services, it is absolutely essential to review the current structure and provide rationalized structure for better performance of H& FW department.

b. The workload of the staff of H&FW department has increased several folds in the recent times. The numbers of national programs have increased over years. The reasons for the increased workload stems from changed pattern of health care including up-gradation of hospitals and increase in bed occupancy rates (48.63% for state in 2010) in hospitals.

c. Because of situations in the past, certain institutions were created which continue to exist even today. It is necessary to review the need for these institutions and reorganize them on rational basis.

d. India in general and Karnataka in particular is passing through a phase of dual burden of Diseases. There is high burden of non communicable diseases along with presence of communicable diseases on the community. The priorities of the department have to change to accommodate the changed health profile of the state. Changing environment, lifestyle changes and expectations of services from community have created heightened need for reorganization.

e. With increased number of programs and demands, the quality of supportive supervision has to be enhanced. With this, the restructuring can enable adequate levels of supportive supervision and provide hand holding support to implementers in the field.

f. The motivation and commitment level of staff at various levels has taken a severe dent due to many reasons. One of the major reasons for low levels of morale is the lack of timely promotional opportunities and delay in resolution of service matters. Hence, it is necessary to reorganize the department for optimal delivery of services without creating much financial burden.

g. The department contains highest number of Group-A officers compared to any other department in the state. However, in the recent past, it is observed that the positions of Medical officers and specialists are not getting filled due several reasons including poor pay scale and lack of attractive career prospects. It is necessary to create new positions within the department to provide clear prospects for entrants and thereby attract new doctors into the department.

3. Objectives

1. To review the existing organizational structure of department of H&FWS and provide a rational structure for providing better quality of services to community
2. To provide new form and shape to the department to meet the aspirations of national programs and to achieve health goals
3. To enable creation of efficient public health system through public health cadre
4. To provide recommendations for efficient management of clinical services and National Health & Family Welfare programs in urban areas
5. To provide implementable recommendations to match the aspirations of Government for efficient delivery of health care services.
6. To understand the perception of the staff and incorporate the suggestions in restructuring of the department

4. Materials and Methods

A. The committee reviewed the following documents for studying the history and current structure of the department regarding creation of public health cadre/department and to address the task of restructuring.

   a. The Karnataka State Integrated Health Policy-2001, Government order No. HFW (PR) 144 WBA 2002, Bangalore, dated 10-2-2004.
   b. Proposed draft of Public Health Directorate for department of H&FWS, Government of Karnataka, Palekar committee (2009)
   c. Report of Task force of Health for Karnataka-2004.
   d. Karnataka Gnana Ayoga report regarding Public Health Directorate
   e. Ferguson report
   f. Establishment of Public health cadre in state by Dr.K.K.Dutta
   g. Study of Public health directorates of other states in India- Advantages and limitations
   h. Report of Independent commission on Health of India, by VHAI

i. Mysore Public Health Services Act, 1936.

j. Relevant legislations/rules and regulations and other documents

   i. Atomic Energy Regulation Board- AERB rules

   ii. Consumer Protection Laws- The COPRA

   iii. Indian Penal Code- Section 269, Acts of commission, omission and Medical negligence

   iv. Biomedical Waste Management Rules & Regulations-1998 and subsequent ammendments.

   v. Pollution Control Act

   vi. Private Medical Establishments Act Karnataka

   vii. Clinical establishments Act, Government of India

   viii. Mysore Public Health Act-1936.

   ix. Food Safety Act-1954 and rules there under.

   x. Notifiable Diseases Act-1948.

   xi. Epidemic Diseases Act-1880.

   xii. Karnataka Public Health services, Recruitment rules of 1960.

   xiii. Social legislations affecting Health

      1. Physically handicapped Act

      2. Minimum wages Act

   xiv. Time bound promotion of Assistant surgeons/ Health officers, 1991.

   xv. Cadre & Recruitment rules, 1991.

B. The committee conducted 35 brainstorming sessions involving in-depth discussions. Each member has submitted individual reports and feedbacks on the objectives. Further, the committee deliberated on each member's suggestions. The process was democratic with clear expression of different views on several topics.

C. The committee conducted field visits and has administered format for collecting the feedbacks from the officials of different levels. A total of 47 staff, from ANM to the Director, HFW, have responded to the requests for feedback. The format is given as annexure. No. 1.c

5. Review of earlier reports and acts.

1. State task force has recommended that there should be district cadre and state cadre of officers.
2. State task force has recommended that a Commission on Health may be constituted as a mechanism to help policy formulation and technical assistance.
3. AERB (Atomic Energy Regulation Board) rules govern and lay down norms for radiation safety and disposal of radioactive sources. Hospitals with 30 beds and above are provided with an X ray machine containing radioactive source. The rules governing AERB are not comprehensively implemented in the department. The department will be held responsible for hazardous effects of radiation.
4. Consumer Protection Laws: The COPRA defines that even if a single patient in one year is charged with any fee (including user fee), it shall come under the purview of COPRA. In view of the above, all PHC's will automatically stay out of the purview of COPRA since they provide free services. But, CHC's, Taluk , District and major Government hospitals charge user fees and hence come under the purview of COPRA. This mandates provision of adequate quality of services, provision of manpower and equipment in these institutions.
5. Biomedical Waste management: There is an urgent need to improve segregation at source, transportation and final disposal of liquid and solid biomedical waste.
6. Private Medical Establishments Act: This act provides for ensuring requisite standards in private medical institutions.
7. **Current structure of the department:-**
    1. **District Hospital:** There are 17 District Hospitals under the control of Dept H&FW. These hospitals have bed strength varying from 100 to 450. The Staff strength in these hospitals needs augmentation in view of increased range and scope of services and consequent increase in workload.
    2. **Taluka Hospital:** These hospitals are facing increased workload as seen in HMIS. These hospitals are points of friction between Public and Staff, as perceived from various feedbacks. Presently, Talukà Hospitals have 30 to 250 bed strength. The Staff sanctioned for this is as per old guidelines, which needs to be rationalized as per needs.

3. <u>Community Health Centre</u>: 180 CHCs are functioning in the State. The Staffing pattern is not uniform.

4. **Primary Health centers (PHC's): PHC's have varied distribution of Medical officers which needs to be rationalized.** Analysis of PHCs reveals that there are 23 PHCs with sanctioned posts of three Medical officers. 301 PHCs with 2 Medical Officers. 26 PHUs have maternity annexes.

5. **Based on the observations, following is the description of doctors to be rationalized:-**

Details of Doctors (as on June 2010)		
Title and current postings	**Number of units**	**Number of MO's** (to be rationalized)
PHC's with 4 Medical officers	1	3
Medical officers from PHCs (3 doctors/PHC)	24	48
Medical officers from PHCs (2 doctors/PHC)	301	301
From Plague control unit	1	1
From Cholera control unit	3	3
Doctors from Leprosy control unit	32	32
LCDR Medical officers	NA	100
PHC's with maternity annexe	34	34
Total	**396**	**522**

Note: Every Doctor has about 400minutes per day for rendering service during official hours. In which he can give professionally effective service for only 200-240minutes per day, during which he can cater to about 50patients.The remaining period has to be devoted to inpatient care, office work, Out-reach activities and Supervision with Monitoring of field activities, along with attending meetings and trainings. Based on this the above details has to looked into for rationalization and reorganization. It is suggested to assess the workload on the above criteria and re-deploy a MO as a 2nd MO from the above pool.

Further, there are several vacant positions in the department: (as on December 2010)

	Sanctioned posts	Working	Vacant posts
Sr,Specialists	1476	1269	207
Specialists	1124	593	531
District level program officers	205	182	23
Taluk Health officers	175	111	64
Dy. Chief medical officers	120	116	4
Senior Medical officers	381	353	28
GDMO's	2586	2488	98

6. **Office of District Health & Family Welfare Officer.** The office of the District Health & Family Welfare Services, is a nerve-centre of Public Health, Primary & Secondary Level curative services. It is also the interface between Panchayath Raj Institutions and the Dept. of H&FW. In view of the above the Public Health Services needs to be strengthened. This would go a long way in achieving the objectives of the Govt. in terms of improvement of Health Indicators, achieving the Millennium Development Goals etc. The Dept. promotes community ownership and Public Private Partnership in implementing the programs and filling in the 'gaps' in the system.

7. **Four Health and Family Welfare Training Centres-Mysore, Bengaluru, Gulbarga, Hubli:** Presently, these institutions are under the administrative control of Director, Health & Family Welfare Services with a Principal and two posts of Lecturers.

8. **Divisional Level Office:** The present scenario has undergone a sea-change since the time of the submission of report of Administrative Reforms Commission (based on which the 4 posts of Divisional Joint Directors were abolished).

9. **State level structure:** Currently, the department of Health has two heads of departments, one is the Commissioner and the other is the Director of HFW services. There is also the Director, SIHFW in charge of training activities. All the earlier reports have recommended creation of posts of Director of Public Health and three additional directors (regional).

10. **Drug Logistic Society**: It is only a procurement agency, doing all the collection of indents, procurement and distribution of all drugs to the health care institutions. It is observed that the present set up has failed in strategic planning. Planned supply management has failed, leading to shortage of drugs in the field and adverse publicity for the department. One of the predominant reasons appears to be failure to take timely technical decisions and guide senior management.

11. The workload on the offices of Joint Director (Medical) and Joint Director (Health & Planning) has increased many folds.

12. **State Institute of Health and Family Welfare services (SIHFW):-**

a. The State Institute of Health and Family Welfare services, is an in house training institute for various cadres in the department. It is also the nodal administrative office for 19 district training centers (DTCs) and co-ordinates with 4 HFWTC's (health and family welfare centers), presently under the control of Director H&FWS, which has to be under the administrative control of Director, SIHFW.

b. During the field visits, there was felt need by most of the interviewees to improve the quality of trainings in general, and providing continued education. The institute can expand its quality and scope of trainings without any additional expenditure to the Government by adopting Public Private Partnerships in imparting quality training and offering diploma courses. It is learnt that SIHFW at Gwalior in Madhya Pradesh has adopted PPP model by entering a tri-partite MoU with Public Health Foundation of India and NRHM.

13. **People deputed to Medical education department:** Many personnel including Casualty Medical officers, staff nurses and other paramedic positions who are from HFW department are deputed to Medical education department. Department of H&FW services is paying retirement benefits and handling service matters of these employees.

Recently, six district hospitals have been taken over by DME. The committee observes that **ten** district hospitals are under the administrative control of DME, thereby reducing career progression and development of its personnel. HFW department has lost about 2500 positions out of these hospitals and this has become a strong deterrent for joining Health & Family Welfare service, as opportunity for serving in those areas is denied.

14. **Observations regarding redundant and excess positions :**

i. Plague control unit: Kolar and Bangalore were endemic for plague between 1932-1963. Though Plague is no more a public health problem, the two institutions continue to exist. The committee suggests the continuation of only Attibele plague control unit located in Bangalore urban district.

ii. Cholera control unit: There are 7 cholera control units located in the districts of Mysore, Chitradurga, Bellary, Gulbarga, Bijapur, Bagalkote and Dharwad. In the present scenario, there is no need for cholera control units to function separately, due to existence of large number of PHCs, rapid response teams and integrated diseases surveillance program.

iii. Leprosy control and eradication units: Presently, the prevalence rate of leprosy in Karnataka is less than 1. The state of Karnataka has achieved leprosy elimination goals. Each DHO is provided with a programme officer for Leprosy control along with a technical team. In spite of this, 34 leprosy control units are functioning in the state with 32 posts of Medical officers and a total strength of 227.

iv. **Malaria** is making resurgence in most parts of the State. In the year 2009, these establishments were disbanded and the DDs were relocated as DDs under NRHM. Malaria Eradication Program is a centrally sponsored scheme for which GoI reimburses the expenditure.

v. **TB hospitals:** There are six hospitals meant for exclusive treatment Tuberculosis. The Government has permitted these hospitals to be converted into either general hospitals or ANM training schools or to close down. It is found that a proposal to convert TB hospital at Mangalore district (Mudushedde) into general hospital is received at the directorate. In respect of other

hospitals, they are non functional but the staff continue to be posted to these posts as head of accounts are operational. The superintendents and other staff can be relocated and these unwanted institutions be closed.

vi. In several districts, the positions of LCDR were created to provide continuance of services in peripheral institutions, when doctors went on long leave or maternity leave. When all the doctors are on duty, the workload on these positions is minimal. Hence, these LCDR posts are to be done with.

15. Feedback from employees in the department

The detailed feedback from employees was sought in terms of strengths, weaknesses, skills needed for work efficiency and suggestions needed to improve work efficiency. The results are presented in **Annexure. 1.C.**

16. Observations on Mysore Public Health Act: The committee made the following observations:

a) Origin and formation of public health and concept of public health was initiated

b) Seven bureaus were set up in the department

c) Cooperation with urban health local bodies started

d) Establishment of rural health wing

e) Public health institutions started submission of case dairies concerned with diagnosis of out breaks and production of vaccines

f) Report of morbidity statistics for 48 diseases

g) Forecasting of epidemics

6. Immediately Implementable recommendations

I. Summary of major recommendations

1. A common cadre-wise seniority list of GDMOs, Specialists/Senior Medical officers and senior specialists/ Dy.Chief medical officers is in vogue in the department. However, it has not been regularly updated over years. **Mandatory upgradation** of seniority list should be done every year by the end of January. This should be published in the departmental web site. It is suggested that a G.O be issued every year in the month of February to publish the seniority list. The common cadre-wise seniority list prepared and updated as above should be the basis for all promotions in the department for both proposed public health cadre and current medical cadre with additional qualifications as required, mentioned in this document. The guidelines for promotion shall be in accordance with seniority as in the **feeder cadre** and merit, and should follow the following norms. The committee strongly recommends that the assessment of merit should be done in terms of requisite qualification and proven track record. Good track record should be interpreted as having demonstrated good leadership, management and supervisory skills in the preceding positions. In addition, the officer should have demonstrated integrity.

    a. Compulsory rural service of 6 years including the contractual period

    b. Taluk health officer: 6 years of rural service + Post graduation in Public Health+ from the pool of Senior Medical Officers.

    c. District level program officer: 10 years + Post graduation in Public Health + from the pool of Senior Medical Officers/Taluk health officers.

    d. District Surgeon and RMO: 15 years + Post graduation in Clinical specialty*+ from the pool of senior specialists in feeder Medical cadre.

    e. District Health & Family welfare officer: 15 years + Post graduation in Public Health + from the pool of common feeder cadre (senior specialists in Public health cadre)

    f. Deputy Directors

        i) Deputy Directors for clinical specialties: 15 years + Post graduation in clinical branches+ from the pool of common feeder cadre (Senior specialists in Medical cadre)

ii) Deputy Directors for Public Health specialties: 15 years + Post graduation in Public Health+ from the pool of common feeder cadre (senior specialists in Public health cadre.)

g. Joint Directors:

i) Joint Directors for medical specialties: 20 years + Post graduation in clinical branches+ from the pool of common feeder cadre (Senior specialists in Clinical cadre.)

ii) Joint Directors for Public Health specialties: 20 years + Post graduation in Public Health+ from the pool of common feeder cadre (senior specialists in Public health cadre.)

Note: The promotions to the position of Joint Directors shall be as per the senority in the common gradation list , along with other criteria. However, Govt. is to exercise due diligence to the Post Graduate qualification during issual of postion orders in accordance with the PG qualification of the Officer.

h. Additional Directors: 20 years + Post graduation in Public Health or medical specialties from the pool of Joint Directors

i) Additional Directors for medical specialties: 20 years + Post graduation in clinical branches+ from the pool of common feeder cadre (Joint Directors in Clinical cadre.)

ii) Additional Directors for Public Health specialties: 20 years + Post graduation in Public Health+ from the pool of common feeder cadre (Joint Directors in Public health cadre.)

i. Proposed position of Director of Public Health: 20 years + Post graduation in Public Health from the pool of Additional Directors* + common feeder cadre (Additional Directors in Public health cadre.)

j. Director of Medical services: 20 years + Post graduation in clinical specialty from the pool of Additional Directors + from the pool of common feeder cadre (Additional Directors in Clinical cadre)

k. Director, SIHFW: 20 years + common feeder cadre (Additional Directors in Public health or medical specialty cadre.)

Note:

a. **Officers with clinical post-graduate degrees can be offered position in public health cadre provided they have already completed post-graduate courses in Public Health at any point of time (as defined in the public health cadre above).**

b. **The term "Rural service" means number of years services rendered in rural areas irrespective whether these years are rendered in regular appointment or under contractual appointment.**

c. **A specialist in Public Health cadre is one who has acquired any post-graduate degree/diploma in Public health, recognized by Govt. of Karnataka.**

d. **A specialist in Medical cadre is one who has acquired any post-graduate degree/diploma in Clinical stream, recognized by Govt. of Karnataka.**

e. **The posts of proposed 3(Three) Regional Additional Directors have to be distributed among medical and public health cadres, abiding by the common seniority list.**

f. **The proposals is to have prospective effect only. The present incumbents may be sent for required training.**

g. **Officers with clinical post-graduate degrees can be offered position in public health cadre provided they have already completed post-graduate courses in Public health at any point of time. (as defined in public health cadre in this report)**

2. **Re-organization and restructuring of the department:** The present scenario, has undergone a sea-change since the time of submission of the Administrative Reforms Commission report (based on which the 4 posts of Divisional Joint Directors were abolished). Hence, the committee has recommended re-organization and restructuring of the department. These are given in the section on detailed recommendations.

3. **Public Health Cadre:** The committee recommends that there shall be three levels in Public Health Cadre namely, Taluk level officers, District level officers and State level officers. The Committee recommends that the entry level for Public health cadre is at the level of Taluk health officer. Government of Karnataka has implemented time bound promotions in 1991-92, wherein, it has

published and updated common seniority list, which is the basis for all service matters.

4. **The committee recommends the following with respect to Public Health Acts/Legislations-**

    a. The committee recommends that AERB rules be strictly followed and the concerned administrative medical officers be held responsible for violation of these norms.

    b. The committee recommends that the department should prioritize allocation of human resources and equipments to the institutions under the purview of COPRA to avoid being liable for punitive action under COPRA.

    c. **Environment safety rules:-**

        i. Pollution control Act: Air and Noise pollution due to generators is to be avoided by providing mufflers.

        ii. Biomedical Waste management: The Committee recommends mandatory retraining of all concerned staff as per present norms.

    d. Standards in Government Hospitals: The Committee recommends that standards will have to be prescribed for Government Health Institutions similar to prescribed in KPMA.

II. Details of major recommendations- Immediate

1. **Public Health Cadre: The committee has the following recommendations regarding Public Health Cadre.**

   The committee recommends that there shall be three levels in **Public Health Cadre** namely, Taluk level officers, District level officers and State level officers. The Committee recommends that the entry level for Public health cadre is at the level of Taluk health officer. Government of Karnataka has implemented time bound promotions in 1991-92. Cadre-wise common feeder seniority list has been published (should be updated), which is the basis for all service matters.

   a) **All the promotions will have to be based on cadre-wise feeder list and required post-graduate qualifications.**

   b) The Committee recommends that this list should be mandatorily updated every year.

   c) For the long-term management of Public health cadre, GDMOs should be given an option after completing **three** years of rural service to pursue post-graduation in public health or clinical services. However, to address the immediate shortfall of public health trained workforce, the state Government has to prioritize and offer PG training as suggested in point 1.A (b.i-iii) below.

   d) The committee recommends that a comprehensive list of officers who have undergone training in both clinical and public health cadre will be created and updated regularly by proposed Deputy Director (HR). Deputy Director (HR) will report directly to proposed position of DGHS.

   e) The committee recommends strengthening supervision at all levels involving field activities.

1.A **The post of Taluka Health Officer should be filled up by a Medical Officer who has completed a minimum of 6yrs of rural service, with Public Health Specialization.** In case of non-availability of such a candidate, , *an MBBS qualified Medical Officer, based on seniority and 6 years of rural service, should be sent to complete a recognized post-graduate diploma or Masters course in Public Health* and posted as Taluka health Officer. There should not be one person holding charge of both Taluka Health Officer and Administrative Medical Officer, at one time, in a taluka.

Mandatory qualifications:-

a) Should be eligible as per Common seniority list in the feeder cadre (with at least **SIX** years of rural service including rural service in the contract period) and postgraduate qualification in public health.

b) A degree /diploma in public health would be a mandatory qualification. The committee recommends the following post-graduate courses as minimum requirements to be qualified as a Public health specialist

   i. A recognized MD in community Medicine or preventive and social medicine

   ii. Masters in Public Health (MPH)/ Master of Science (Public Health)/ or recognized as equivalent by universities/ Government.

   iii. Post-graduate diploma in public health or equivalent offered by recognized universities or recognized institutions

1.B: At present, there is shortfall of qualified public health professionals in the department to opt and continue in public health cadre. The state Government has to conduct counseling with immediate effect to identify Medical officers interested in pursuing public health cadre and to pursue public health qualification. At the counseling, list of Medical officers (who have completed six years of rural service and based on seniority) should be prepared based on the common seniority, and be given option to complete post-graduation in public health. Counseling should provide options of both Public health training and Post graduate courses in clinical branches.

a) **The committee strongly recommends that deputation of medical officers is to be done in batches of 30-50 to recognized Public health institutions in the state/country to complete the backlog of training. After the successful completion of postgraduate training, these officers should be posted as Taluk Health Officers and they would continue in Public health cadre for the remaining service period.**

b) The committee feels that Public health is a field-based discipline with associated administrative and technical skills of management. Hence, no dilution should be accepted by the Government in providing highest quality of post-graduate training and orientation in imparting public health skills.

c) Those who do not opt for post-graduate qualifications in either clinical or public health specialties and those do not attend counseling (after the notification on departmental website), **shall be deemed to have** foregone all the promotional opportunities in the department. Such officers would continue as Medical officers for the rest of their career with time bound financial benefits. The age for the above shall be as in Karnataka civil service rules.

Note: For public health postgraduate qualifications listed above, recognition of the degree/diploma should be done based on the existing or future norms to be established by Ministry of Health and Family Welfare, Government of India, MCI or Public Health Foundation of India and Government of Karnataka.

The Committee notes that similar recommendations have been suggested by several earlier committees. The Karnataka State Integrated Health Policy-2001, Karnataka State Task Force on Health, Ferguson report, Dr. Palekar Committee, Karnataka Gnana Ayoga and Karnataka Public Health Act (2010-draft under discussion by KILPAR) require that a directorate of Public Health has to be created in the Department of Health and Family Welfare services.

1.B Second level of Public Health Cadre- District level

The Committee recommends that the second level of public health cadre be at district level as a unit comprising of District Health & Family Welfare officer and all the district level program officers. This level provides leadership for efficient Public Health delivery system.

i. **District Health and Family welfare Officers**: The Committee recommends that the eligibility for the post of District Health & Family Welfare Officer should be that of seniority cum merit and public health specialist.

ii. The officer should be eligible as per common seniority list in the feeder Public health cadre. He/She should have completed a minimum of **15 years** of regular service inclusive of 6 yrs of rural service, with a recognized Public Health degree/diploma. He/She should possess management and supervisory skills demonstrated either as Taluk health officer/Administrative Officer at CHC and/or as a district level program officer. The officer should have a good track record.

c) A degree /diploma in public health would be a mandatory qualification. The committee recommends the following post-graduate courses as minimum requirements to be qualified as a Public health specialist

iv. A recognized MD in community Medicine or preventive and social medicine

v. Masters in Public Health (MPH)/ Master of Science (Public Health)/ or recognized as equivalent by universities/ Government.

vi. Post-graduate diploma in public health or equivalent offered by recognized universities or recognized institutions

iii. **District Program Officers**: These Officers should be Senior Specialists/Deputy Chief Medical Officers who are eligible as per seniority cum merit, who have completed 6yrs of rural service and a total of at least **10 years** of service, as depicted in the organo-gram. In the present scenario if such a candidate is not available, then a Medical Officer in the cadre of Senior Specialist/Deputy Chief Medical Officer who has eligibility as per seniority and has undergone a course/training in Public Health should be considered.

iv. In the present scenario if such a candidate may not be available, hence a Medical Officer as per common seniority list in the feeder public health cadre applicable, should be deputed to pursue post-graduate courses in Public health as mentioned in recommendations above.

v. The Committee strongly recommends that only on successful completion of post-graduate courses in Public health, the eligible officers be posted as District program Officers.

vi. ***To address immediate shortage of qualified public health professionals in the department, a one-time intensive course is to be offered for the eligible doctors as per the following recommendations. This measure is recommended ONLY for district and state level officers to address immediate shortfall.***

a. **A Public health institution recognized by Government, preferably in Karnataka, must be requested to design and offer a customized course** to suit the requirements of the public health needs of Karnataka state.

b. This customized course should be offered as follows:-

i. The proposed course shall be module and assignment based. The course shall have two modules of three months each and assignments to be carried out in the place of work.

ii. The candidate shall take qualifying examination on completion of both modules. The successful candidates shall be conferred Post-graduate diploma in public health.

iii. A Cluster of 10 DHOs, 10-15 District level program officers and 30 THOs should be posted for in-service training of three months duration.

iv. The course can be offered in the following manner

    1. 2011-12: Conduct training for three batches in a year by completing the module-1 inclusive of assignment/s for all the DHOs, 20-45 District level program officers and 60 THOs.

    2. 2012-13: Conduct training for three batches in a year by completing the module-2 and assignment for all the DHO's, 40-90 DLPO's and 90 THO's.

    3. 2013-15: Conduct training for second term for covering remaining DLPO's and THO's.

v. The Committee feels that deputing 10 DHOs, 10-15 DLPOs and 30 THOs at a time to the residential training of three months is essential and will not adversely affect the functioning of the department.

vi. The Committee recommends that funds for offering intensive public health training for immediate needs is to be met with funds from NRHM. According to the NRHM norms, the unit cost of conducting one-time-training is estimated to be around one lakh per candidate per module and assignment orientation training.

vii. While deputing officers for intensive training as mentioned above, the department has to ensure that these officers meet the provisions of KCSR rules.

1.C. Third level of Public Health Cadre- State level and Establishment of Public Health Directorate

To provide coordination, data integration and technical supervision across the department, the committee strongly recommends that a position be created for coordination to be occupied by an officer with technical qualification. This has been suggested by the Planning commission, Central Commission on Health and the present Union Minister for Health and Family Welfare. Health sector is a fast growing sector with exponential increase in content and scope of services being rendered. It needs better technical coordination and convergence across several technical functions. This is the second biggest department in the state.

The Committee **recommends** the following":-

1. The third level of public health cadre shall be at the state / regional level as a unit comprising of Director of Public Health, additional directors, joint directors and deputy directors. This level provides leadership for the entire state for efficient Public Health delivery system so as to ensure the goals set by national health plans such as, 'millennium development goals for health'.
2. A post of Director is to be created to exclusively head the public health directorate. In total, there will be two posts of Director; one for Public health and another for Medical Services.
3. The job responsibilities of ***Director of Public Health (DPH):***
    i. Shall function as state public health authority.
    ii. Shall oversee functioning of DHOs, THOs and PHCs.
    iii. Public Health Laboratory will report to Director of Public Health.
    iv. Director of Public Health shall function as state authority for IDSP, Communicable Diseases, Malaria and Filaria etc.,
    v. PD (RCH), JD (CMD), JD (M&F), AD (IDSP), Demographer, JD (IEC) and JD(PHI) will report to Director of Public Health.
    vi. Anti Tobacco Act to come under purview of DPH.
    vii. The Director (Public Health) will be Head of the directorate of Public Health. He/She will be in charge of all administrative and financial matters related to the cadre of Public Health and programs implemented in public health activities, and will be supervising officer for AD (RCH), AD(CMD) and AD(AIDS).

viii. The Director(Public Health) will also be the State Food Commissioner, under the Food Safety & Standards Act 2006.

4. The post of Director of Public Health be a selection post guided by the following criteria:-

   i. A senior Public health Specialist, with minimum **20 years** of service in the department as per seniority cum merit.

   ii. Must have completed postgraduate courses in Public health as per recommendations given earlier in this report.

   iii. Has shown exemplary achievement in upholding the principles of public health.

   iv. Has shown good leadership skills in earlier positions held.

   v. The selected incumbent Director of Public Health should be in accordance with C&R rules.

5. **The present pool of talent at state level is heterogeneous. It is imperative to offer opportunity in the form of a one-time intensive course in public health. This is to be offered for the eligible Deputy Directors, Joint Directors and above as per the following recommendations:-**

   a. This shall only be a temporary measure to address the pressing needs of department on an emergency basis.

   b. This one time course is a temporary arrangement and should not be continued once shortfall of public health professionals is met.

   c. Eligible Medical Officers from the senior specialist cadre (according to common seniority list) should be sent to pursue PGDPHM during the years 2011-13 **on PRIORITY.**

   d. **For the current year:- A Public health institution recognized by Government and which has active field oriented engagement in public health, must be requested to design and offer a customized course** to suit the requirements of the public health needs of Karnataka state. The curriculum shall be decided in house in consultation with retired public health specialists in Government and external experts.

e. Officers as per seniority in the common seniority list should be deputed to pursue a crash course in "health policy, management and health research"

f. This customized course should be offered as follows:-

   i. The proposed course shall be of thirty working days in duration.

   ii. This crash course can be offered by reputed health research institutes in India or abroad.

g. While deputing officers for this training as mentioned above, the department has to ensure that these officers have met eligibility (minimum rural service of 6 years and based on seniority cum merit, and aptitude for public health). The department has to ensure that deputed officers should have at least two years of service before retirement to utilize the experience gained in this course for implementation.

2. Re-organization and restructuring of Health & FW department

2. A State Level :

a. The Committee recommends that a "**Technical Core Group**" advisory in role be formed at the Commissionerate.

Suggested norms are as follows:-

- This group needs to review and suggest policy matters governing efficient health service delivery, planning, program implementation, procurements, review of laws pertaining to health, disaster management, evaluations of schemes of Government, PPP and innovations in health service delivery.
- They should meet at least once in six months.
- This Committee will act as **"think-tank"** at State level.
- The committee should consist of

  i. Director General Health Services- Chairman
  ii. Director of Public Health- Member
  iii. Director of Medical Services- Member
  iv. Director, SIHFW - Member
  v. Additional Director (RCH) – Member
  vi. Additional Director (logistics) - Member
  vii. One DHO nominated by DGHS
  viii. One DS nominated by DGHS
  ix. Representative from KGMOA
  x. One representative from MOH.
  xi. Related subject experts:- such as lawyer, procurement specialist, insurance specialist etc.
  xii. Representative from Arogyashree and insurance schemes.
  xiii. Representative from externally aided projects.
  xiv. Invitees from the Committee
  xv. Recognized academicians and experts from institutes of excellence.

- The deliberations of the meeting of this group will have to be recorded, and submitted to the Secretary, H&FW Department.

b. <u>Creation of the Post of Director General Health Services :</u>

The Committee recommends the creation of Director General of Health Services.

The job responsibilities for Director General Health Services to be as follows:-

i. It is suggested that DGHS should head both the Public Health and the Medical Services wings of the department.

ii. He/She shall be designated as the Head of department with complete administrative and financial powers delegated to HODs. He will be functional under DPAR as is the case now with regard to director health services.

iii. The position of DGHS should be by selection and should be from among the pool of Directors comprising of Director of Public Health, Director of Medical Services, and Director (SIHFW).

iv. Chief Administrative officer, Chief Vigilance officer, Chief Accounts officer and Financial Adviser shall work directly under DGHS.

v. JD (Planning) and JD (HET) work directly under DGHS.

b. <u>Job responsibilities of position of Director, Medical Services :</u> *(DMS)*

The Committee recommends that the Director of Medical Services to have following job responsibilities.

i. Shall oversee functioning of District surgeons, Taluk hospitals and CHCs

ii. Shall function as State authority for Organ transplant act.

iii. Medical reimbursement of legislature, department and other departments.

iv. Special programs of the department such as Burns unit, Dialysis unit, Geriatric wards, ICU units, Blood banks, social legislations, monitoring of physically handicapped certifications, private medical establishment act, monitoring of trauma centers and cancer patient concessions etc.

v. Supervision of collection, usage and audit of accounts of hospitals pertaining to user fees collected by Arogya Raksha Samithi.

vi. JD (Medical), JD (Ophthalmology), JD (Leprosy), JD (TB) will report to the Director Medical services.

c. Drug Logistics Society

i. The Committee recommends the need 'indent' should be scrutinized, approved and forwarded from the immediate higher officer, eg. PHC to Taluka Health Officer to District Health Officer (In concurrence with ZP planning) and higher authorities.

ii. This could be done at the level of proposed Regional Additional Director. The consolidated indents could then be transmitted to AD drug logistics under intimation to DGHS Karnataka.

iii. The process for preparation of indent for ensuing year should mandatorily start in the month January, i.e. 1st month of last quarter of the financial year at the taluka level, reviewed at the district level in the month of February.

iv. The review should be completed at the divisional level in the month of March and the information should be transmitted to the Logistic society under intimation to DGHS Karnataka in the month of March itself.

v. The drug logistic society presently has two Officers of the rank of DD. These Officers are found to be engaged in finalization of indents and procurement processes. Due importance needs to be given to follow up action in respect of drugs declared as sub-standard quality and redistribution of drugs as per need (segregation, replacement and disposal of substandard drugs).

vi. The disposal of date expired drugs needs to be done as per pollution control norms. However there is need to monitor data collection and disposal as per norms.

A senior post in Technical position of the rank of Joint Director may be posted in the Drugs and Logistic society.

d. A post of training officer is functioning under the supervision and control of Joint Director (HET), under overall control of Director, H&FWS. This

post needs to be shifted, along with lean and be placed under the administrative control of Director, SIHFW.

e. The workload on the offices of Joint Director (Medical) and Joint Director (Health & Planning) has increased many folds. Hence, it is suggested that an additional post of Deputy Director be created by relocating one of the redundant posts in the department. THIS WILL ALSO NOT ENTAIL ANY ADDITIONAL FINANCIAL BURDEN TO THE STATE.

f. **State Institute of Health and Family Welfare services (SIHFW):-**

   i. SIHFW needs to be developed as an Apex center for excellence in training Health and Family Welfare Officers.

   ii. To improve the quality of training in SIHFW, the faculty can undergo "Future Faculty Program" under PPP without any additional burden to State Government. The outline of this program can be worked out with Public Health Foundation of India as follows:-

      - They can be selected as per the existing Government norms.
      - Additional criteria for funding agencies can be brought in place.

   iii. Deputy and Joint Directors at SIHFW: The department has hitherto identified "Master Trainers" under several programs. The Committee recommends that this talent pool be identified and only officers from this pool can be posted as Deputy and Joint Directors at SIHFW. The other channel of entry could be through Future Faculty Program, which identifies interested officers early in their career and subject them to rigorous training in specialties including teaching methods.

g. **Special Needs:** The Committee recommends that there is special need for creating the following positions by re-designating or by creation of posts.

   i. Deputy Director (Human resources and Social Legislations): She/He can also work as protocol officer to take care of visiting dignitaries.

ii. Deputy Director (Disaster Management): Without duplicating the job responsibilities of JD (CMD) and JD (M&F), She/He shall be in charge of control room and liaison with JD (CMD) in case of outbreaks of communicable diseases and shall also be the Nodal Officer of the department to liaison with disaster control centre of the Government.

iii. Deputy Director (Public Private Partnerships): This will include EMRI, PPP, Externally aided projects and insurance schemes. Monitoring of PPP initiatives, collection and analysis of the data as per needs of the Dept. and M &E of the Dept., e.g. EMRI, Mobile Health Unit, Citizen Help Desk, Arogya-Bandhu, Out-sourcing of super specialty hospital at Raichur etc and other PPP's.

iv. Deputy Director (Procurements): The role shall be procurement of equipments, medical audit of equipments, monitoring of condemnation and disposal of equipments like ultrasound, X-ray, ventilators, Boyle's apparatus, operating microscope, generators etc

v. Deputy Director (Nutrition): is currently functioning as DD (SAST-Suvarna Arogya Suraksha Trust). He should continue as DD (nutrition) to provide focused attention for implementation of GoI sponsored iodized salt usage, Vit A administration, prevention of Anaemia and management of programs for other micronutrient deficiencies.

vi. Deputy Director (Special programs): To monitor SAST, physically handicapped act, monitoring of user-fee usage etc. Inter-departmental coordination with entities created to address the specific needs of the Dept., e.g. KSAPS, SAS Trust liaison with Yeshaswini trust.

vii. Assistant Director (4 positions)

- Research Officer (RCH) to be renamed as Assistant Director (Immunization) reporting to PD (RCH).
- Research Officer (Malaria) to be renamed as Assistant Director (Communicable diseases) reporting to JD (M&F). This position will also be responsible for coordination with health wings of urban bodies.

- The increase in the work load due to programs such as midterm expenditure, MTEF framework, RFD framework etc has been creating recurrent operational problems in the department. Hence, two new positions of Assistant Directors need to be created
    - Assistant Director (Planning)
    - Assistant Director (Medical)

      -to be placed under Joint Director (Planning) and Joint Director (Medical) respectively.

viii. Deputy Director (Drug Logistics): The need of the user institution varies depending upon outbreak of diseases, fairs and festivals and outbreak of seasonal epidemics. It is of utmost importance to make available the needed drugs at the right place at the right time. For this the status of drug availability in various wear houses should be viewed and the needed drugs transported to the needy warehouses. Apart from the above, the follow-up of the preparation of the indents from various districts under various programs need to occur at directorate. Availability of critical and essential drugs at hospitals needs to be monitored at directorate. For this, an officer of the rank of DD needs to be created. She/he should report to Director, Medical services.

2.B Divisional Level Offices: The situation has undergone a sea change, resulting in the present scenario, since the report of administrative Reforms Commission (based on which the 4 posts of Divisional Joint Directors were abolished). The Committee is of the opinion that there should be a divisional level officer of the grade of 'Additional Director' for the following reasons:

i. The District Hospitals need focused monitoring, especially in newer initiatives like burns, dialysis, geriatrics, tele-medicine etc.

ii. The Taluka Level Hospitals at present are the least monitored institutions. There is a need for focused monitoring to improve service delivery, quality of services and resolve public grievances.

iii. With the onset of Zilla-Panchayat System, Primary Health Centres and all the clinical institutions having less than 100 beds, stand transferred to Zilla-Panchayat. The technical monitoring & supervision is done by the

Dist H&FW Officer, at the District level, and by State Nodal Officer for a period of only 3 days in a month.

iv. Instances of 'lack of co-ordination', are being noticed between State controlled institutions and those coming under Zilla-Panchayat, especially in the implementation of National Health Programs, which is an area of concern. This is affecting the 'quality' and 'performance' of the Dept. as a whole.

v. Poor Audit and Inspections of Primary Health Centres, Community Health Centres, Mobile Health Clinics, Tribal Health Units, Taluka Health Offices, District Surveillance Offices etc. are an area of concern. Scores of these institutions have not been audited for over a decade.

The Committee held a series of interactive-sessions, with the Field Staff, at all levels. During the interactions, following issues of concern have surfaced, which need to be addressed.

i. Frustration in non-resolving/inordinate delay in resolving their 'service matters', like sanction of leave beyond 60 days, declaration of 'probationary period' for Group B, C & D, time-bound promotions and stagnation increments for Group B & C, enquiries and disciplinary actions etc. Presently, field staff from all over the state have to make frequent visits to the State Headquarters, thereby defeating the stated intention of the Govt., of decentralization and provision of quick redressal, without causing mental agony, financial-loss and loss of man-days of productivity.

The Committee recommends that in the interest of improvement in administration and de-centralization, the shifting & re-designation of the posts of Additional Director (Primary Health), and 2 Additional Directors from KHSDRP may be re-designated as **'Regional Additional Director'**, placed at Gulbarga, Belgaum and Mysore. Bangalore being the Headquarter of the Dept., the functions of Regional Additional Director of Bangalore may be carried out by the Director (Public Health). As the posts are already existing along with support staff and vehicle, they may be shifted to the new position. THIS WILL NOT ENTAIL ANY ADDITIONAL FINANCIAL BURDEN TO THE STATE. Routine office expenditure shall be met out of departmental funds.

Further, **to enhance the supervision of taluk level hospitals, the following model could be considered.**

RMO-District Coordinator of Hospital Services (DCHS)

The senior most RMO in the District Hospital will be designated as the District Coordinator of Hospital Services. The suggested job responsibilities of DCHS include the following:-

i) Supervision and control of all hospitals and institutions within the district.
ii) Liaison with Deputy Commissioner, Zilla Panchayath and Community representatives.
iii) Liaison with District level officers of Health Department like District Health Officer and head of District Training center.
iv) Periodic and random inspection of hospitals.
v) Selection, recruitment, appointment and cadre management of Class IV employees within the district.
vi) Transfer and posting of paramedical, clerical and other Class III employees within the district.
vii) Disciplinary matters of hospital personnel in the District. (Class IV)
viii) Pre – audit of bills presented by hospital and Institutions within the district.
ix) Payment of bills to institutions.
x) Budget control
xi) Compilation and reporting of accounts for the District.
xii) Periodic and random financial inspection of subordinate institutions.
xiii) Monitoring review of equipment and maintenance of stores.
xiv) Temporary redeployment of equipment, Vehicles etc., with in district.
xv) Constitution of district level standing and adhoc medical boards.
xvi) Organization of emergency medical relief and hospitalization in times of natural calamities and unforeseen situations.
xvii) Organization of medical coverage for VIP visits.
xviii) Coordination and rendering of hospitalization and surgical facilities of routine and intensive Family Planning work.
xix) Collection, reporting and dissemination of Medical Intelligence and Bio – Statistics.
xx) Review, monitoring and coordination of referral services.
xxi) Monitoring quality of Nursing Services and other paramedical services.
xxii) Monitoring quality of Medical Records services.
xxiii) Section Officer for Maintenance of buildings.
xxiv) Maintenance work of all buildings, Civil works etc. within the district.
xxv) Protection of lands- storage of land records of health care institution, etc.

However, the Committee strongly recommends the setting up of the Regional Additional Director's Offices, delegating the present powers in respect of above issues from the Directorate, H&FW, including the powers of counter-signatures of bills of hospitals coming under their preview.

The following job-responsibilities are recommended for *Regional Additional Directors:*

a. To provide support to the Director of Public Health/Director Medical Services and proposed DGHS regarding supervision and monitoring of district Hospitals especially in newer initiatives like treatment for burns, dialysis, geriatrics, tele-medicine etc.

b. To provide support to Director Medical Services regarding supervision and monitoring of Taluka Level Hospitals.

c. To provide support to Director of Public Health regarding supervision and monitoring of Primary Health Centres and all clinical institutions having less than 100 beds.

d. To provide support to Director of Public Health/Director Medical Services and proposed DGHS regarding co-ordination between the department controlled institutions and those coming under Zilla-Panchayat, especially in the implementation of National Health Programs.

e. To be officer in charge of 'service matters, like sanction of leave beyond 60 days, declaration of 'probationary period' for Group B, C & D, time-bound promotions and stagnation increments for Group B & C, enquiries and disciplinary actions excluding major enquiries.

f. To provide support to Director of Public Health/Director Medical Services and proposed DGHS regarding Audit and Inspections of Primary Health Centres, Community Health Centres, Mobile Health Clinics, Tribal Health Units , Taluka Health Offices, District Surveillance Offices etc.

g. To scrutinize the need 'indent' from peripheral institutions, approved and forwarded through proper channel. The consolidated indents could then be forwarded to AD drug logistics under intimation to DGHS. The process for preparation of indent for next year should mandatorily start in the month January, i.e. 1st month of last quarter of the financial year at the taluka level reviewed at the dist level in the month of February.

h. The general delegation of powers can be at par with that of Regional level officers in the other departments subject to availability of budget.

2.C Revival of the office of divisional DD (NAMP) in the 4 divisions of Mysore, Bengaluru, Belgaum and Gulbarga. Malaria is still a public health problem in the state. This office needs to be revived for focused anti malarial activities by re-allocating the shifted posts. The NMEP programme is presently 100% centrally sponsored scheme with the expenditure met by GOI.

2.D People posted in Medical education department:-

The Committee recommends that there should be clear-cut policy decision regarding staff working in Medical college hospitals/hospitals under the control of medical education department,who are to be repatriated to the Dept of H&FW and DME may take action to make good for the same at their end. The committee recommends that dichotomy should be stopped. These repatriated personnel shall be relocated in the Dept of H&FW vacancies.

2.E Appointment of AYUSH doctors against the position of Medical officer: The Committee strongly recommends that no AYUSH doctor can be posted against the post of a Medical officer (MBBS). The Committee feels that all postings of AYUSH doctors currently against the sanctioned posts of Medical officer requiring MBBS qualification should be cancelled.

2.F Ten district hospitals are managed by DME. The Committee recommends that all these hospitals should be handed over to HFW department and be utilized for clinical services as in the case of Mangalore and Davanagere.

2.G Revival and restructuring of several wings :

The details are as follows:-

a. Plague control unit:- The plague control unit at Kolar may be disbanded and the sanctioned staff under the relevant head be relocated to needy institutions. Details provided in HR report.

b. Cholera control unit:- These units may be disbanded and staff sanctioned may be relocated as suggested by the departmental reorganization committee.

c. Leprosy control and elimination units:- The Committee feels that the 227 posts in these units including 32 posts of Medical Officers could be relocated and leprosy units disbanded.

d. Handigodu disease control unit at Shimoga: This is a rare disease supposed to be localized to Shimoga district. In view of the persistence of the disease, the committee feels that unit should be continued.

e. KFD (Kyasanur Forest Disease) unit: these units are functioning in the districts of Shimoga, Dakshina Kannada and Uttara Kannada. The Committee feels that these units should also be continued.

f. DD (NMEP):-Since Malaria is a disease of public health importance, the Committee feels that office of DD(NMEP) should be revived in their original headquarters of Mysore, Belgaum, Bangalore and Gulbarga and work under the overall control of proposed offices of Regional Additional Directors.

g. TB hospitals: In respect of non functional TB hospitals, the superintendents and other staff can be relocated and these unwanted institutions may be closed.

h. Vaccine Institute, Belgaum: Vaccine Institute is closed down but the machinery still exists and three staff are continued under original heads for maintenance. Staff can be taken back from Institute and be relocated to the office DHO, which is located in Vaccine institute.

i. KHSDRP: Ten positions of Deputy Directors and 2 position of Joint Director and 2 position of Additional Director from KHSDRP may be relocated to Health department after the conclusion of the project during March 2012.

j. Some of the areas under earlier rural PHCs have been notified as urban centers due to re-notification of urban areas. The Committee feels that these centers be continued in the H&FW department.

k. The Committee feels that since 1 PHC is available for 15000 population on an average (achieved IPHS standards) and considering the intense workload of NRHM, the Medical officers deputed outside the department should be recalled to H&FW department.

l. Filaria control unit: There are 2 units one at Raichur and one at Bengaluru. Filaria control program is no longer a vertical program and hence these staff may be relocated to H&FW department.

m. LCDR positions: The Committee feels that these posts should be available for relocation to needed areas as decided by Government as there is a need to standardize staff position at several levels of hospitals.

Based on the above recommendations, re-allocation of doctors may be effected as follows:-

Provisional scheme for re-allocation of posts of Medical Officers	
Title and current postings	**Numbers**
Regional Additional Directors	3
Deputy Directors (NMEP)	4
Deputy Directors (State level programs)	4
Assistant Directors	2
RMOs to District Hospital	17
CMOs to District Hospital (3 for each DH)	51
CMOs to Taluk Hospital (2 for TH)#	219
CMOs to CHC's (1 for CHC)	180
Proposed DCHS position (1 for district)*	30
Total	**510**

*= This is for new positions of DCHS to strengthen supervision of Taluk hospitals and CHC's.

#= All Taluk hospitals have been administratively upgraded to 100 beds. In reality, TH's having 30 beds, 50 beds are also functioning. These hospitals might be given reduced number of CMO's.

2.H. Revision of C& R rules:

Periodically number of national programs implemented by the Department have increased considerably. In view of this,

- Drafting C & R rules is needed for the new positions created and to be created on the recommendations of the Committee (Refer to Organogram)
- The Committee recommends that C&R Rules may be reviewed and revised every five years.

2.I Health and Family Welfare Training Centres in Mysore, Bengaluru, Gulbarga and Hubli: The Committee feels that the administrative control of these institutions including the lien and head of account are to be shifted and be placed under the administrative control of the Director, SIHFW.

- At the Sub-Centre Level: the present criteria of one JHAF per sub-centre population of 5000 in plain areas and 3000 in hilly and tribal areas is adequate, and should be followed (JHAFs are assisted by ASHAs, who are placed one per 1000 population). The present structure of one JHAM per two JHAF sub-centers is to be continued. However, there are 10000 sanctioned posts of ANMs in the state, wherein 8143 are in sub centers. The remaining ANMs are working in Taluk and District hospitals as maternity ANMs. These posts could be relocated, based on the above population criteria to needed areas in the districts. This should be done on the basis of latest census of figures of 2011. This would not entail additional financial burden as the expenditure on salary and related budgeted heads is already budgeted.

2.J Primary Health Centre:

a. In the State, at present , there are 2310 PHCs against a need of 1279 PHCs. This works out at one PHC for 15000 population against the norms of population policy of one PHC per 30000 population. In view of the above, the committee recommends that each PHC shall have only one post of Medical Officer. The State is implementing 24x7 PHC models, Model PHCs, which under the guidelines would entail, additional MO, which should be appointed under relevant programs.

b. Presently the Medical Officer at the Primary Health Centre is designated as GDMO under time-bound rules 1992. The post should be re-designated as 'Medical Officer". Consideration of the above would entail suitable amendments in C&R rules. 'Induction training' for the Medical Officers should be continued. The training has to be comprehensive and of a duration of minimum of 3 months, with mandatory field oriented work with technical, supervisory, administrative, communicative, financial and managerial skills.

2.J. Community Health Centre: 180 CHCs are functioning in the State. The Staffing pattern is not uniform. The Committee recommends sanctioning a post of 'anesthetist' in all CHCs in addition to the sanctioned posts of OB-G, Physician, Pediatrician and a Dentist. The posting of MBBS graduates against a 'Specialist' post to be dispensed with as it defeats the objective of providing service of a specialist. **The committee recommends that hospitals with less than 100 beds including CHC's, hitherto under administrative control of DHO's should be provided additional technical supervision by respective District Surgeons or by proposed RMO-DCHS. Hospitals with 100 and above beds will be under administrative and technical supervision of District surgeon or by proposed RMO-DCHS.**

2.K. The Taluka Health Office : The Committee is unanimous in its opinion that this Office should be strengthened (present and revised organogram enclosed). The Committee recommends that financial powers to Taluka Health Officers be enhanced. (Details of the cadre are provided in section of recommendations under Public Health cadre.) Amendment to general delegation of financial powers is to be considered and proposed.

2.L Taluka Hospital: It is recommended that the post of 'Casualty Medical Officer' (additional posts to be re-appropriated from existing pool) to be sanctioned in the Taluka Hospitals, to enhance and maintain the quality of specialist services and to maintain adequate emergency care services, around the clock. These posts have to be filled by common feeder cadre subject to willingness. To increase the efficiency of administration in Taluka Hospitals, it is suggested that second senior most doctor to be entrusted with responsibilities of 'Resident Medical Officer' who shall be responsible for internal administration, as recommended by job chart. The Government may consider additional charge allowances.

2.M. District Hospital: The post of 'Casualty Medical Officer' is to be provided (additional posts to be re-appropriated from existing pool) at the District Hospitals, to enhance and maintain the quality of specialist services and to maintain adequate emergency care services, around the clock. These posts are to be filled with MBBS Medical Officers who have completed a minimum of 13 years of service, which includes 6yrs of rural service in it. To increase the efficiency of Administration within District Hospitals, it is suggested to create a post of 'Resident Medical Officer', who shall be responsible for internal administration, as recommended by job chart. The Government may consider additional charge allowances.

2.N Office of District Health & Family Welfare Officer: Details of the cadre are provided in section of recommendations under Public Health cadre.

2.O District Level Program Officers: These Officers should be Senior Specialists/Deputy Chief Medical Officers who are eligible as per seniority cum merit and who have completed 6yrs of rural service and a total of at least 13 yrs of service, as depicted in the organogram. **(Details of the cadre are provided in section of recommendations under Public Health cadre.)**

2.P Nineteen District Training Centres: DTCs are functioning under the Administrative control of Director, State Institute of Health & Family Welfare. The Principals of these 19 DTCs units should be senior specialists, preferably with a post-graduate qualification and eligible as per seniority cum merit. They should have completed 6 yrs of rural service and a total of at least 15 yrs of service.

2.Q Joint Directors for Four Health and Family Welfare Training Centres at Mysore, Bengaluru, Gulbarga, Hubli: Presently, HFTC's are headed by principals in the rank of deputy directors under the administrative control of Director, HFW. The Committee recommends that the posts be upgraded to the level of Joint directors delegating the supervision of DTC's of respective regions. The committee also recommends transferring administrative control of these institutions (including the lien and head of account) to Director, SIHFW.

A post of training officer of the level of Deputy Director is functioning under the supervision and control of Joint Director, HET, under overall control of Director, H&FWS. This post also is to be shifted (along with lien and head of account) be placed under the administrative control of Director, SIHFW.

2. R State Transport Organization:

- The department to meet its varied needs has a fleet of vehicles of varied categories eg: Jeeps, Cars, Tempos, Ambulances, vaccine carriers, mini buses etc.,
- The total number of available vehicles in the department is 1551. With the coming into existing of Zilla Panchayats, vehicles attached to the office of the District Health & FW Offices, Programme Officers, Tq. Health Offices & hospital less than 100 beds. CHCs, PHC's, stand transferred to Zilla Panchayath. Their maintenance and technical assistance & expenditures are being done by the concerned Zilla Panchayats.
- Rest of the vehicles are available in the 100 beds hospitals, district hospitals, other major hospitals and Directorate of Health & FW Services, and State Level Programme Officers. Against the availability of 1551 number of vehicles 1046 number drivers are working in the department.

The Govt., in order number a.ku.ka 01 pasvir 2005 Bangalore dated 07/November 2005 has declared the post of Group-D and Drivers as unnecessary and has permitted for out sourcing of vehicles and manpower wherever necessary. The department also has a maintenance wing called the Workshop located at Magadi Road, in an area of 3 acres. Here Garages, pits, maintenance equipment and manpower for maintenance of vehicles is available & maintenance work is under taken. The present staff position in the workshop is as follows;

Sl. No.	Post	Sanction	Working	Vacant	Remarks
1	Transport manager	2	1	1	
2	Service Engineer	2	2	-	1.workshop 2. Office
3	Skilled Tradesman	27	20	7	9-workshop 11-other sections
4	Skilled assistants	42	20	22	15-workshop 5-other sections
5	Watchman	4	1	3	

- Among the above as per Govt. order A ku ka 01pasvir 2005 Bangalore dated 07/November 2005 annexure 'C' the post of skilled tradesman, and Service Engineer stands cancelled on retirement of the existing incumbent.
- 58 vehicles are available at the Directorate of Health Services level for its multi aphasic activities and their maintenance is attended to here. The committee within its mandate suggests that a decision to continue /strengthen State Transport Organization needs to be taken up. If necessary a separate committee may be set up to look into the matter.

2.R Departmental Offset Press:-

- In the Department of Health & Family Welfare there is an Offset Press, established in the year 1972. This press has a sanctioned strength of 40 (sanctioned, working & vacant details enclosed). The Press was established under Centrally Sponsored Scheme and salary is being borne under head of account 2211.

The Press was functioning well till about 2001-02and was catering to the printing requirements of the department and also Kutumba a Wall Paper News Bulletin was printed. The Press for several reasons like vacancies of Posts, lack of maintenance has been defunct since about 10 years. The press is provided with HMT model machine manufactured in 1986-87 year. This machine is not compatible with the present digital printing and also it is learnt that spare parts of this machine are not easily available.

It is a paradox that in spite of existing press no in-depth effort has gone into either reviving the press or winding it up and the department continues to incur expenditures

by out sourcing the printing needs including publication of Kutumba News Bulletin. This while the expenditure on idle staff continues.

Review of the staff position reveals that the total staff strength is 38. The details are as under:- 4 are Group-C, and others are Group-D officials and it would be a difficult proposal to revive the press in the above circumstances.

In view of the above the committee recommends the closure of the offset-press and shift/absorb existing staff based on staff eligibility to vacant positions in the department or the press be revived.

6.B Recommendations- Road Ahead

1. The Committee is unanimous in its opinion that Taluk health office should be strengthened (present and revised organogram enclosed as Annexure.2). The committee recommends considerable enhancement of financial powers to Taluka Health Officers which may entail amendments to general delegation of financial powers.
2. The Committee feels that a comprehensive 'Orientation Training' is a must for all the candidates posted as District H & FW Officer.
3. It is recommended that statutory responsibility is entrusted on the appropriate authority for publication common cadre-wise seniority list for all the cadres in the department inclusive of GDMOs, Specialists/Senior Medical officers and senior specialists/ Dy.Chief medical officers.

6.C Issues to be addressed

1. The department is deputing medical officers for one year training in mental health, dialysis etc. These are essential trainings for rendering the required services by the department. However the committee has not addressed the status of these trainings (with respect to equivalence to post graduate diploma/degrees) for purposes of career advancement.
2. Vaccine institute at Belgaum was producing anti rabies vaccine till recently. This unit has been shut down by an executive order of the Government. Accountant General classifies the unit as an public undertaking. The closure needs to be done according to the norms of public undertaking. The Government needs to address this issue

7. Summary

Health is a State subject, hence the infrastructure and organization varies from state to state. A strong Public Health Organization in the state is an important requisite for improvement of health standards, which is having a bearing on the socio-economic development of the State.

A good foundation of Public Health is considered as complimentary to Curative Medicine, as a part of "Comprehensive Health Care". The concept of reorganization of the department and creation of Public Health Cadre is an earnest step towards realizing various goals. This will go a long way in fulfilling the aspirations of the Health care seekers, Health care providers, especially Medical Officers working in the rural areas in the state. This will go a long way and be etched in history as an important initiative to promote 'public-health' for the people of Karnataka. This may serve as a 'model' for other States to emulate.

The Committee sincerely acknowledges the vision and support from Secretary to Government, Department of Health & Family Welfare. The committee thanks Project Administrator, KHSDRP for his wholehearted support and keen interest in this task. The Committee thanks all the officers and officials who have directly and indirectly contributed in this endeavor. We hope that the committee's efforts would be fructified through implementation of its recommendations. We earnestly believe that our report meets the expectations and aspirations of the Government in towards delivery of efficient services to the common man and also bring much needed structural modifications in the department.

Annexure.1.a : Government order constituting the committee dated 9th August 2010.

PROCEEDINGS OF THE GOVERNMENT OF KARNATAKA

Sub:- Formation of Public Health Cadre/ Directorate in the Department of Health & Family Welfare -reg.

Read:- 1. Proceedings of the 20th Meeting of the Programme Steering Committee, dt: 17th and 22nd June 2010.
2. Govt. Order/No.:HFW/KHSDRP/Sect/Spl.A-1/2007, dt:29.11.2007.

******

Preamble:

The Programme Steering Committee, in its 20th meeting held on 17th and 22nd June 2010, has directed to constitute a committee to look into the issue of formation of a Public Health Cadre/ Directorate in the Department of Health & Family Welfare and submit a report. It also suggested that retired Directors of Health and Family Welfare Services, representatives of Karnataka Government Medical Officers Association (KGMOA) and representatives from State Institutions may be included in the Committee. The Deputy Director (OD), KHSDRP would coordinate and provide necessary logistic support to the Committee.

Hence the following Order.

Government Order No. HFW/KHSDRP/OD/PHD/16/10-11 Bangalore, dt: 09.08.2010

Under the circumstances mentioned in the preamble, Government are pleased to constitute a Committee to look into the issue of formation of a Public Health Cadre/ Directorate in the Department of Health and Family Welfare, comprising of the following members:

1. Dr. P.M. Halagi, Former Director, H & FWS - Chairman
2. Dr. S.C. Dharwad Joint Director (Retd), H & FWS - Member
3. Dr. Giridhar Babu, IIPH, Hyderabad - Member
4. Representative of KGMOA - Member
5. Dr. Suresh Shapeti, I/c JD (H&P), H&FWS - Member Secretary

The Committee will examine the following:

a) Already proposed/ drafted draft of Public Health Directorate for Department of Health and Family Welfare, Government of Karnataka.
b) Taskforce of Health for Karnataka - proposal and report.

2)--

c) Karnataka Jnana Ayoga Report.
d) Study of Public Health Directorates of other States in India – Advantages and limitations (if any).
e) Present need of Preventive Public Health Care, PPP initiatives and other innovative schemes to improve healthcare delivery.
f) Relevant legislations/acts/rules and regulations/ other documents.
g) Suggest a comprehensive, implementable reorganisation of the present Department of Health and Family Welfare.
h) The road ahead in the formation of Public Health Cadre/ Directorate in the Department of Health & Family Welfare Government of Karnataka.
i) Any other relevant issues.

The above Committee shall submit it's report on the establishment of Public Health Cadre/ Directorate in the Department of Health and Family Welfare, Government of Karnataka within two months from commencement of the work.

The members of the Committee are eligible for sitting fees, TA/DA as per prevalent provisions.

By order and in the name of the
Governor of Karnataka

(M. Shashidhar)
Deputy Secretary to Govt.
KHSDRP,
Health and Family Welfare Department

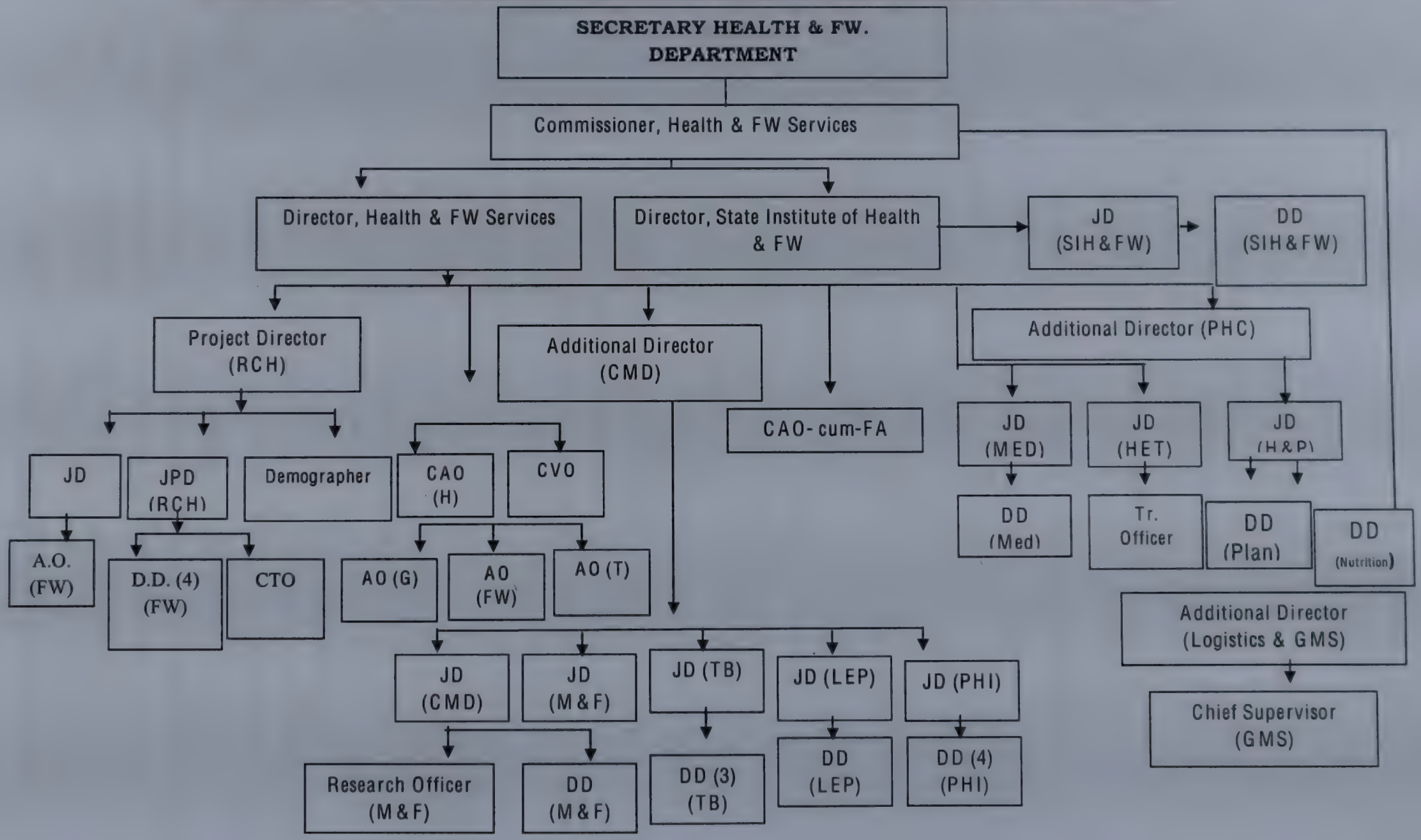
To,

The Compiler, Karnataka Gazette for publication in the Gazette.

Copy of information to:

1) The Accountant General in Karnataka, Bangalore.
2) The Secretary to Govt. Department of Health & Family Welfare.
3) The Commissioner, Health. Family Welfare & AYUSH Services.
4) The Project Administrator, KHSDRP and ex-officio Additional Secretary to Govt, Department of Health & Family Welfare.
5) The Director, Health & Family Welfare Services.
6) The Project Director, RCH.
7) The Deputy Project Administrator, KHSDRP.
8) The Chief Administrative Officer, KHSDRP.
9) The Chief Finance Officer, KHSDRP.
10) The Deputy Director (OD), KHSDRP.
11) The Accounts/Budget Section, KHSDRP, Bangalore.
12) The all concerned Medical Officers.
13) Office/Spare copies.

Annexure – 1.b: THE ORGANIZATION CHART - STATE LEVEL - EXISTING



Divisional / District Level Organization chart

Director, Health & Family Welfare Services

4 Deputy Directors (NMEP Zone)	District Health & Family Welfare Officer • Dist . T.B. Officer • Dist. Malaria Officer • Dist. Leprosy Officer. • Dist. RCH - Officer • Dist. Health Education Officer • Dist. Surveillance Officers • Dist. Blindness Officer • Dist. Cholera Officer • Dist. Nursing officers Taluk Health Officers • Taluk Health Officer • Medical Officers Community Health Centres • Medical Officers Primary Health Centres • Medical Officers, Primary Health Units. • Medical Officers, (AYUSH) • Medical Officer National Leprosy Control Centre, Modified Leprosy Control Unit.	Dist. Surgeon, Medical Superintendents of Major & Specialised hospitals	1. Principal H & F WTC. (DIVI) 2. Principal H & F W (DTC). 3. Principal, ANM Training Centres 4. Principal LHV Training Centres

Annexure.2: Feedback from employees in the department

- **Strengths:** Field skills (15), training (10), Organization development (7), leadership skills (6), , staff strength (6), communication (5), confidence (5), effective IEC (4), Mentoring (4), commitment (4), M& E (3), knowledge (2), location (1), infrastructure (1), opportunities (1), use of computers (1) and invalid (8)
- **Weakness:** Lack of resources (11): *(lack of A.V aids (4), lack of vehicles (4), Others (3))*, Shortage of manpower (9), Lack of interest in skill upgradation by higher officers (7), lack of commitment (6), Interference in duties (by politicians, public and associations, 5), lack of mentoring (5), lack of training (5), lack of communication (4), bad behavior (4), lack of monitoring (3), lack of supervision (3), lack of time management (2), poor leadership (2), lack of coordination (2), lack of role clarity (1), corruption (1), lack of dedication (1), lack of infrastructure (2), improper planning (1), lack of recognization (1), lack of drugs (1), non-participatory planning (1), lack of healthy environment (2), conflicting duties (1), trained manpower (1), workload (1), no job satisfaction (1), seniority (1), SIHFW (1), No weakness (1), invalid (2), discrimination of programs (1)
- **Skills needed for work efficiency:**
  - Training and continued education: CME: (18), Induction training (2), Training technology (1), Deputation for higher studies (1), Hands on training (1),
  - Attitudinal skills: Commitment (10), planning s (3), soft skills (2), Communication skills: IPC (6), IEC (8), Management skills (1), Leadership skills (4), Administrative skills (2) Implementation skills (2), Knowledge (3), Mentoring (4), Staff friendly environment (3), M & E skills (2), Computer skills (1), Augmentation of HR (1), Invalid (12), Don't need any skills (1)
- **Suggestions needed to improve work efficiency:**
  - Good Governance practices (3), Good infrastructure (5), Proper utilization of existing talent pool (4), Community participation (4), Promotions by seniority (2), merit (1), reform C& R rules (1), Financial support for trainings (1), Improve supervision (1), Staff-friendly and clean environment (2), Filling vacancies (7), Improve training (2), Improve resources (3), Security (2), Vehicle support

(1), Improve AV Aids (2), Motivation (1), Increase in salary (3), Increase in mobility support (2), Improved time management (1), Proactive planning (1), Innovation (1)

- **Threats:** PRI Interference (10), Security threats (6), No threats (5), Lack of commitment (4), Lack of better communication from higher officers (3), Non co-operation from Public (3), Frequent transfers (2), Non head-quarter stay (2), Lack of vehicles (2), Workload (2), Non co-operation from staff (1), Lack of coordination (1), Lack of discipline (1), Non participatory planning (1), Unwarranted disciplinary actions (1), Lack of staff (1), Lack of training (1), Procedures as bottle necks (1), Not considering seniority for promotions (1), NGO's (1), Lack of will (1), Lack of political will (1), Lack of knowledge (1), Health of health staff (1), Less opportunities for promotions (1), Corruptions (1), Lack of time (1)

Annexure.3: Following is the abstract of financial expenditure.

ESTABLISHMENTS	Rs in Lakhs
Office of the Director General of Health Services	38.07
Office of the Director, Medical Services	24.03
Partial new burden, and partly supported by redistribution of staff	
Regional establishments	286.24
By partial additional burden, mostly by redistribution of staff	
Total	**348.34**

Note: It is unavoidable that during restructuring of the department, there will be some unavoidable additional financial outgo with respect to creation of posts, office establishments, supportive staff and other necessary requirements. The committee has pragmatically analyzed the issue and identified posts, which could be relocated in view of the present scenario and has been prudent. In totality the suggested new posts add up to 512 posts. However, most of these posts though new positions with new job responsibilities in reality these posts can be filled by relocating, posts identified as redundant. However strengthening of certain Institutions and creation of new posts entails an additional expenditure as follows.

	Rs. In lakhs
Office of the Director General of Health Services	Rs 38.07
Office of the Director of Medical services	Rs 24.03
Regional establishments	Rs.286.24

Annexure.3.A: Proposed expenditure for creation of Director General Health Services

Office of the Director General Health Services

Rs in lakhs

Posts	Pay Scales	No of Posts to be Sanctioned	Average Pay	Dearness Allowance	Pay + DA	Total
	Rs		Rs	Rs	Rs	Rs
Director General	37400-67000	1	52200	32625	84825 x 1	84825
Gazetted Assistant	10800-20025	1	15412	9633	25046 x 1	25046
Office Superintendent	10000-18150	1	14075	8797	22872x1	22872
Stenographer	7275-13350	1	10312	6446	16759x 1	16759
First Division Assistant	7275-13350	1	10312	6446	16759 x 1	16759
Second Division Assistant	5800-10500	1	8150	5094	13244x 1	13244
Data Operator	5800-10500	1	8150	5094	13244x1	13244
Driver	5800-10500	1	8150	5094	13244 x 1	13244
Group D	4800-7275	2	6037	3774	9812x 2	19624
						225617 X12
Total Amount Required						**Rs 27.07**

Recurring	Rs 27.07
Non Recurring	
Vehicle	Rs 8.00
Computer	Rs 1.00
O E	Rs 2.00
TOTAL	**Rs 38.07**

Annexure 3.B: DEPARTMENT OF HEALTH AND FAMILY WELFARE

Office of Director- Public Health

Rs in lakhs

Posts	Pay Scales	No of Posts to be Sanctioned	Average Pay	Dearness Allowance	Pay + DA	Total
	Rs		Rs	Rs	Rs	Rs
Director	24450-31800	1	28125	17578	17578 x 1	45703
Stenographer	7275-13350	1	10312	6446	6446x 1	16759
Second Division Assistant	5800-10500	1	8150	5094	5094 x 1	13244
Driver	5800-10500	1	8150	5094	5094 x 1	13244
Group D	4800-7275	2	6037	3774	3774x 2	19624
						108574 X12
Total Amount Required						**13.03**

Recurring	**13.03**
Non Recurring	
• Vehicle	Rs. 8.00
• Computer	Rs. 1.00
• O.E	Rs. 2.00
	Rs. 11.00
Total	**24.03**

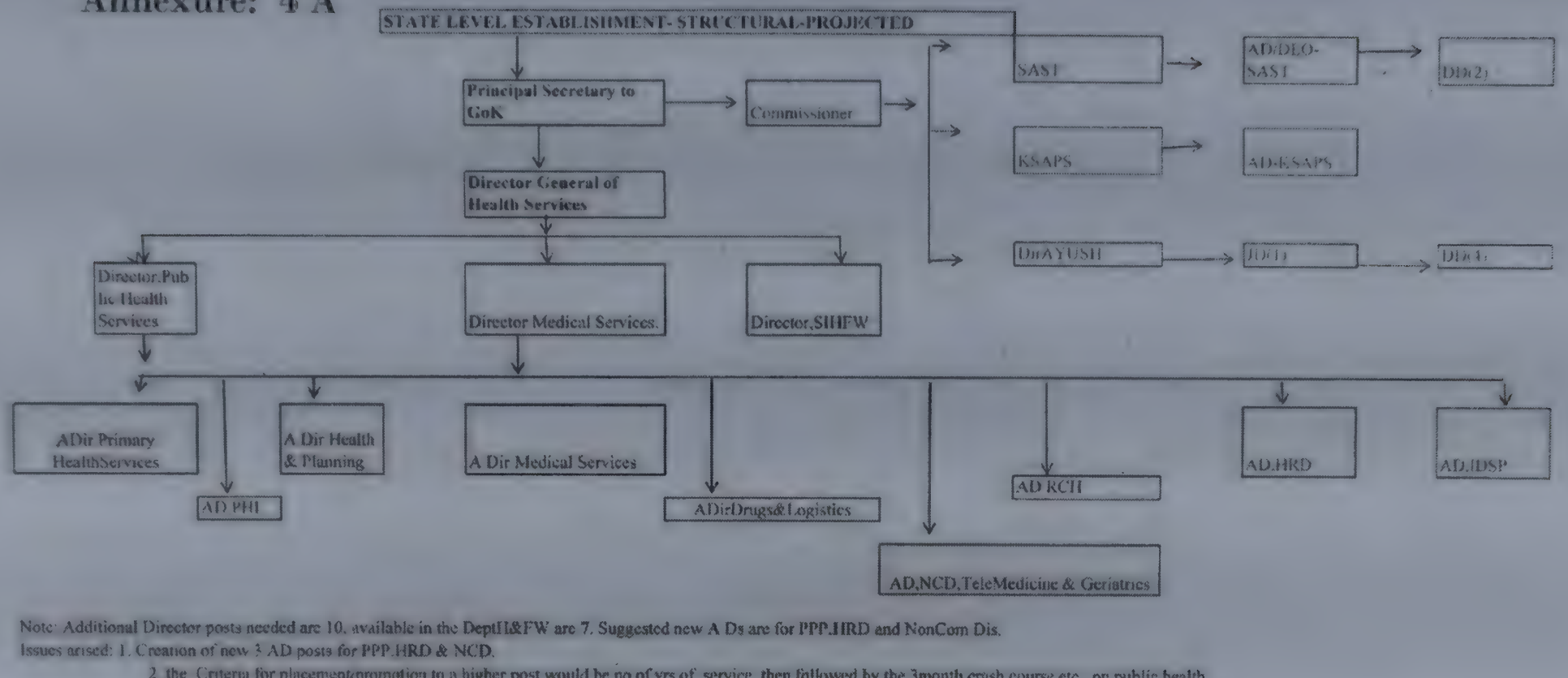
Annexure.3.C: Proposed expenditure for creation of Regional establishments : DHFWS

Rs in lakhs

Posts	Pay Scales	No Of Posts to be Sanctioned	Average Pay	Dearness Allowance	Pay + DA	Total
Additional Director	22125-30300	1	26212	16382	42594 x 1	42594
Deputy Director	18150-26925	1	22537	14086	36623 x 1	36623
Gazetted Assistant	10800-20025	1	15412	9632	25044 x 1	25044
Health Supervisor	8825-16000	2	12412	7758	20170 x 2	40340
Superintendent	10000-18150	3	14075	8797	22872 x 3	68616
Asst Statistical Officer	10000-18150	2	14075	8797	22872 x 2	45744
First Division Assistant	7275-13350	4	10312	6445	16757 x 4	67028
Second Division Assistant	5800-10500	4	8150	5094	13244 x 4	52976
Clerk Cum Typist	5800-10500	2	8150	5094	13244 x 2	26488
Stenographer	7275-13350	2	10312	6445	16757 x 2	33514
Driver	5800-10500	2	8150	5094	13244x 2	26488
Group D	4800-7275	4	6037	3773	9810 x 4	39240
						504695 X12
Amount Required for one Establishment						**60.56**
Amount Required for four Establishments						**242.24**

Recurring	242.24
Non Recurring	
Vehicle	32.00
Computer	4.00
O E	8.00
TOTAL	**286.24**

Annexure: 4 A



Note: Additional Director posts needed are 10, available in the DeptH&FW are 7. Suggested new A Ds are for PPP,HRD and NonCom Dis.

Issues arised: 1. Creation of new 3 AD posts for PPP,HRD & NCD.

2. the Criteria for placement/promotion to a higher post would be no.of yrs of service, then followed by the 3month crash course etc., on public health.

3.Post of AD at SAST to be established.

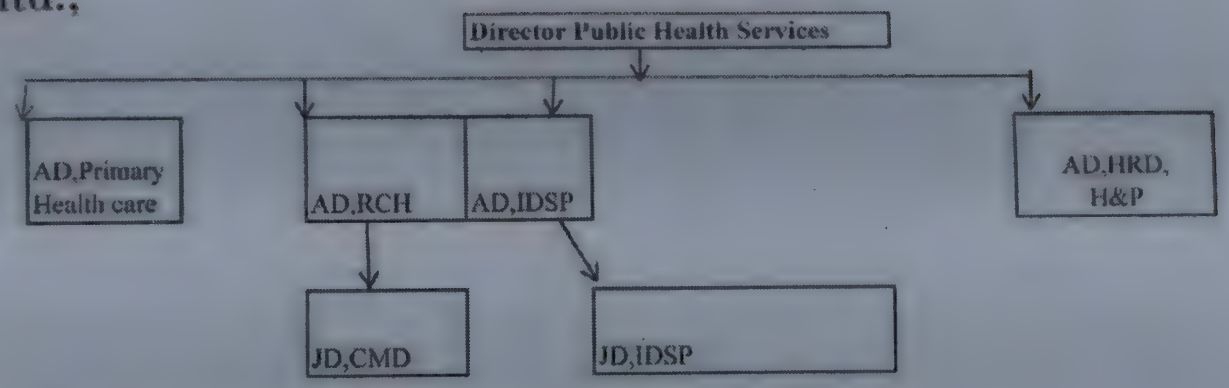
4.AD,IDSP would also look after CMD.

5. AD, KSAPS shall be from Public Health Wing.

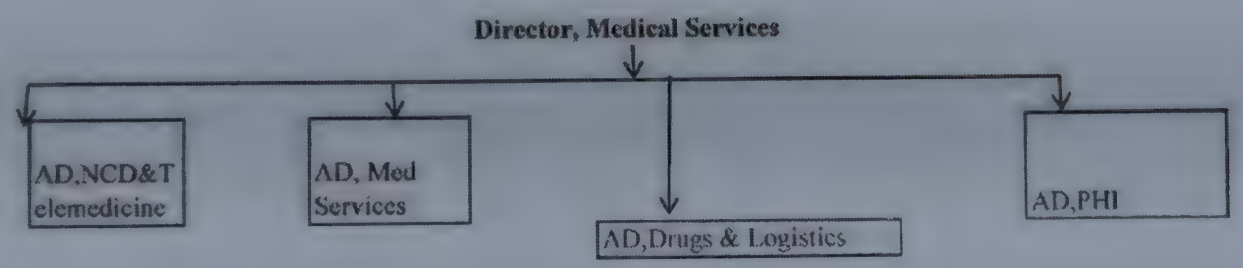
6. AD, NCD shall be responsible for NCD,Geriatrics & Telemedicine.

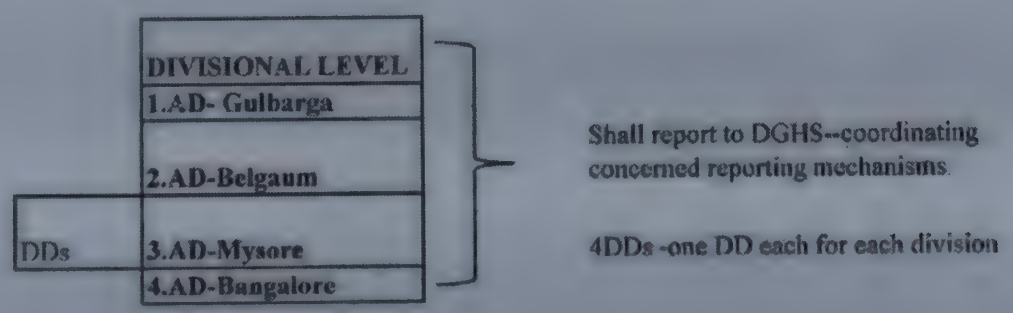
7. AD, CMD shall look after the Disaster Management.

Annexure: 4 A contd.,



Note: The Divisional Joint Director, shall be of the Additional Director Cadre in the Dept H&FW.





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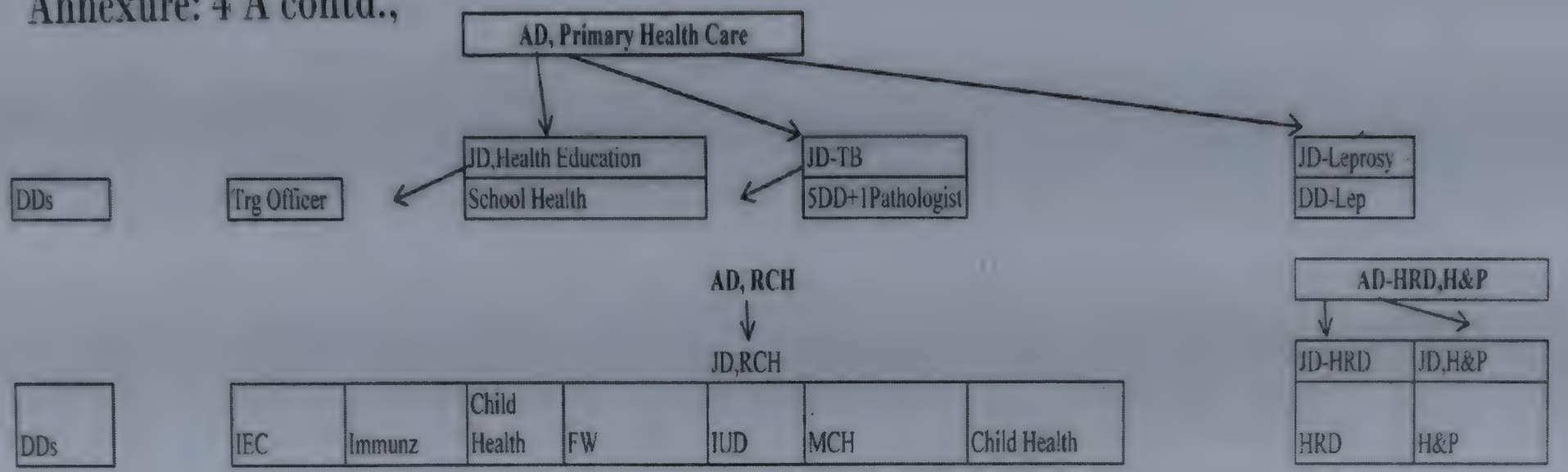
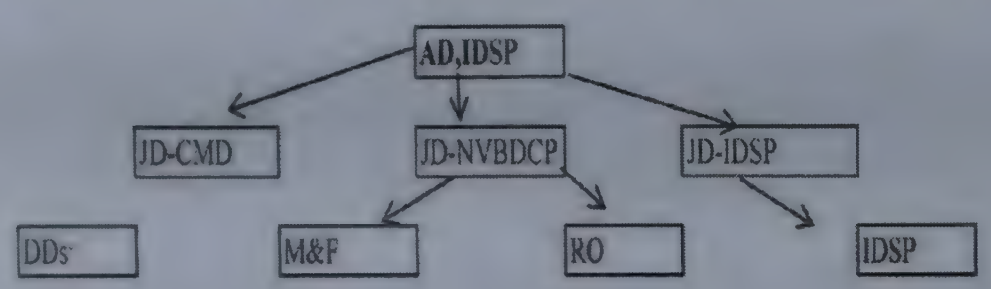
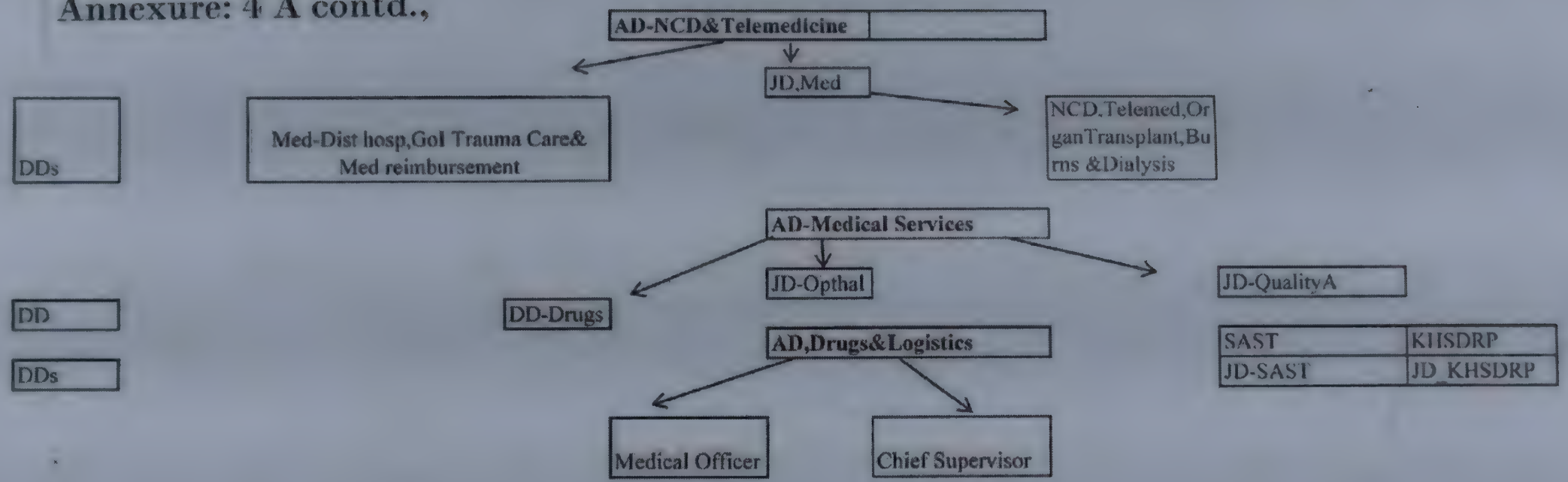




Annexure: 4 A contd.,



Note: The below to be relocated: under AD Medical Services

KSAPS

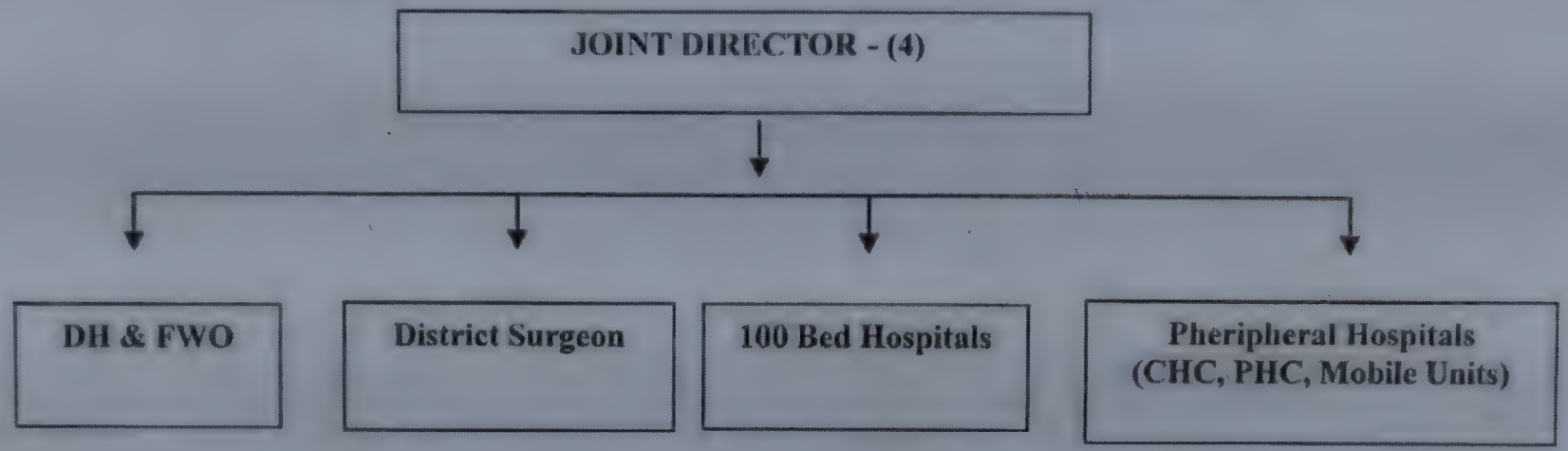
JD-KSAPS

**DD-HRD: to be established under JD-HRD.'

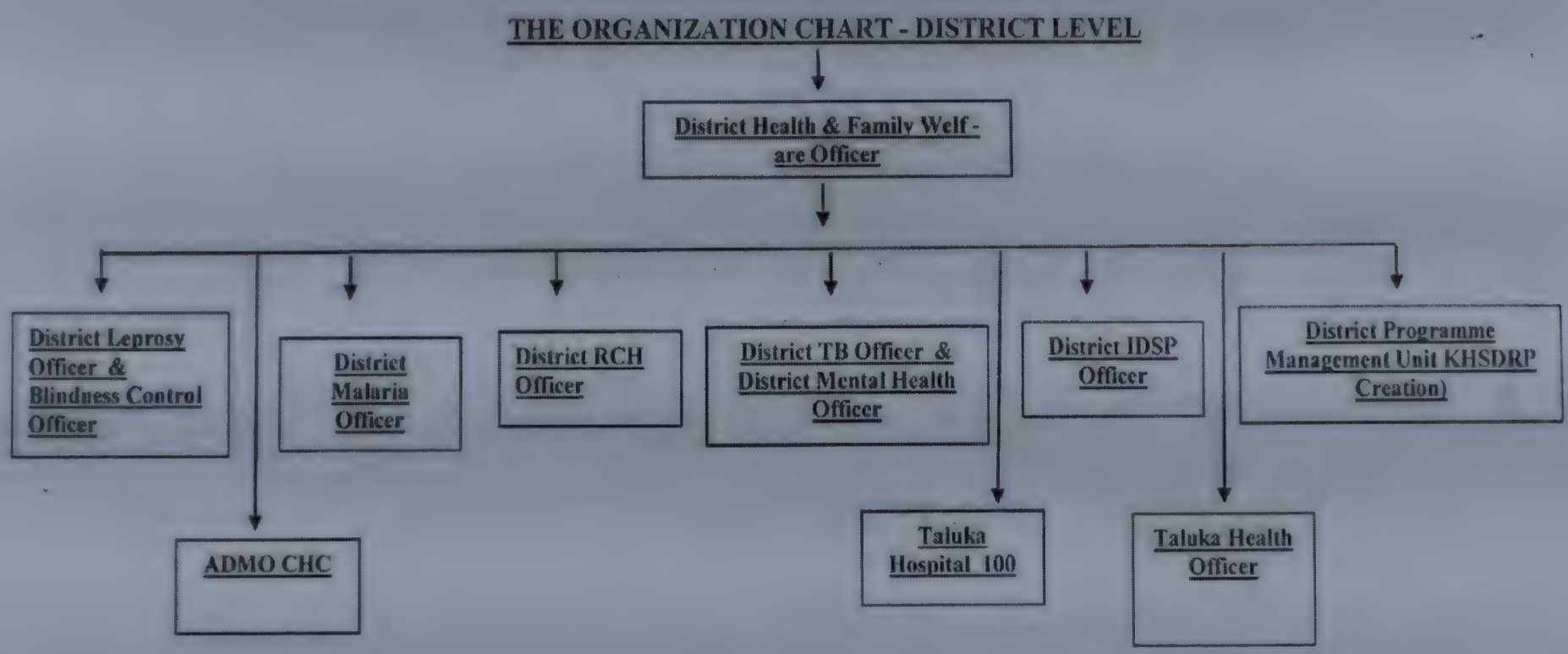
Trg Officer under JD HET to be relocated to SIHFW

Annexure: 4 B

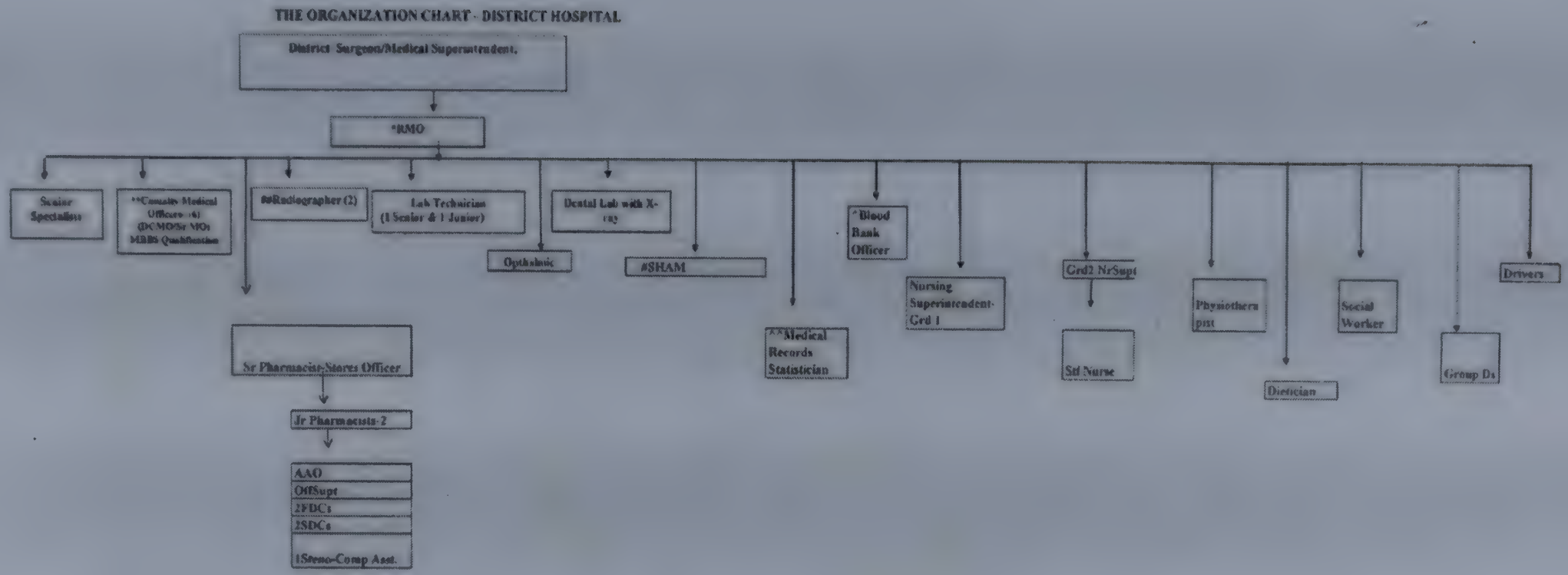
THE ORGANIZATION CHART - DIVISIONAL LEVEL



Annexure: 4 C


THE ORGANIZATION CHART - DISTRICT LEVEL
District Health & Family Welf - are Officer
District Leprosy Officer & Blindness Control Officer
District Malaria Officer
District RCH Officer
District TB Officer & District Mental Health Officer
District IDSP Officer
District Programme Management Unit KHSDRP Creation)
ADMO CHC
Taluka Hospital 100
Taluka Health Officer

Annexure: 4 C contd.,



Note: * RMO post is to be established in the newly created District Hospitals

** Casualty Medical Officer posts are also to be established in all the 17 DH under the Dept H&FW

The services of SHAM who has lean at ANMTC, may be utilised

Xray technicians who are exposed to >20exposures or >1 1/2 hrs of exposure time

^ Blood Bank Officer shall be in position where Blood Banks are established

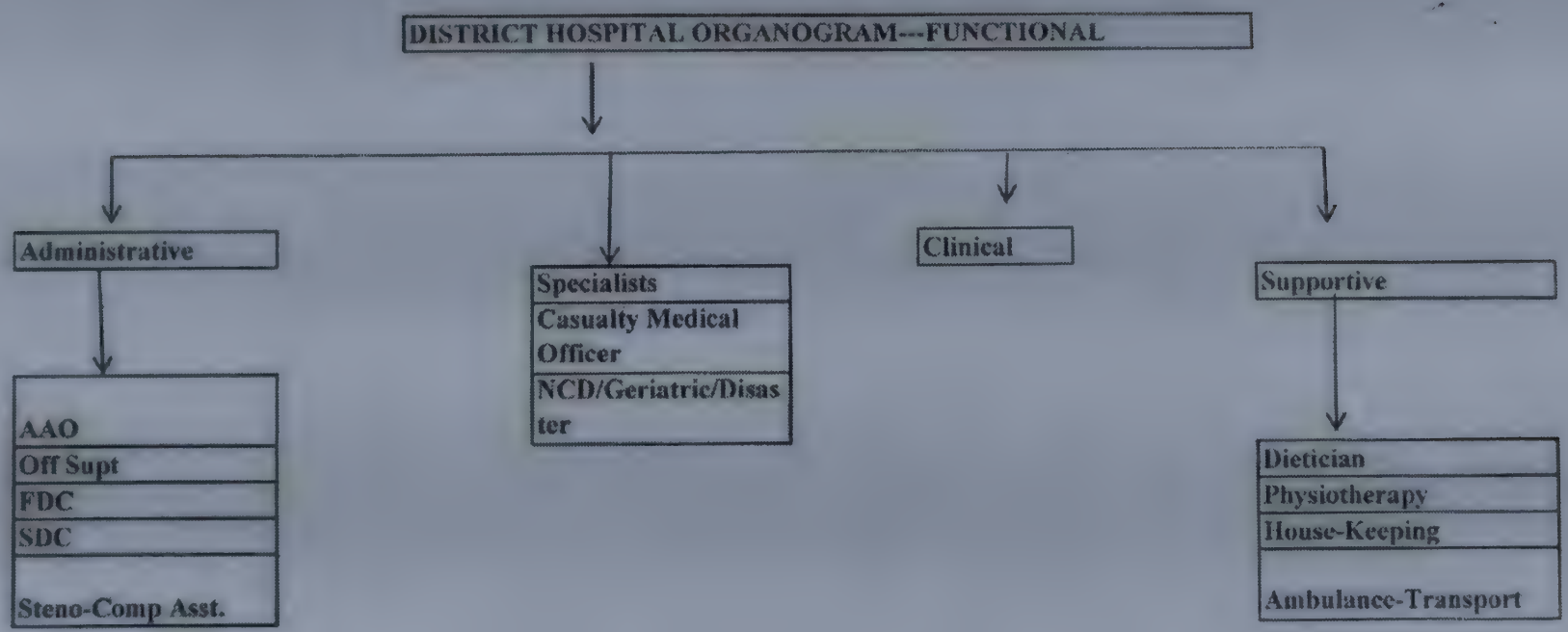
^^ Medical Records Statistician post to be established in all the 17 DHs under Dept H&FW

Post of Physiotherapist to be established if not available.

Social Workers with MSW shall do counselling for all needy patients

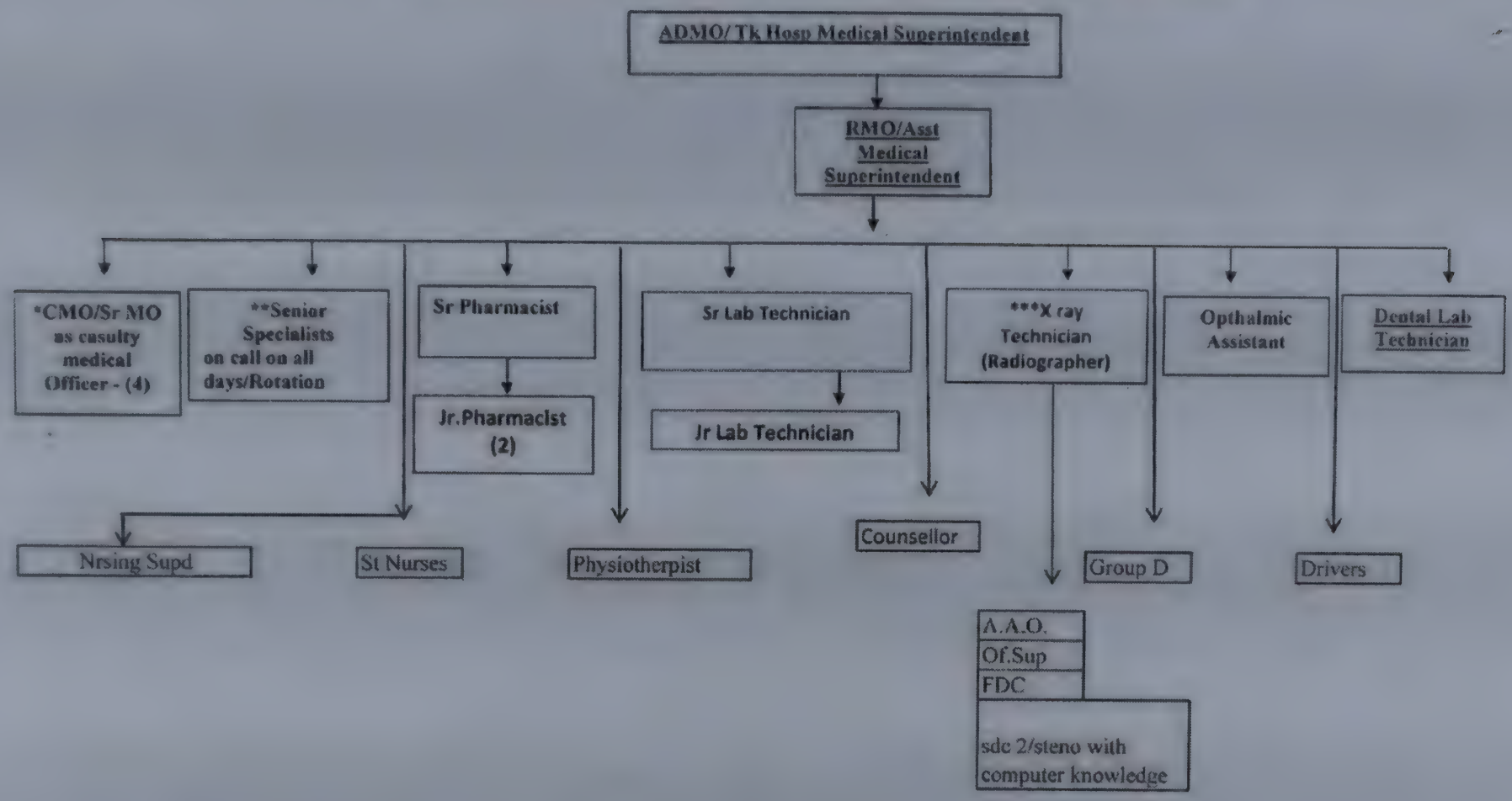
Public Relations shall be looked after by the Citizen Help Desk(outsourced)

Annexure: 4 C contd.,



Annexure: 4 D

THE ORGANIZATION CHART - TALUKA LEVEL HOSPITAL (100 BED)



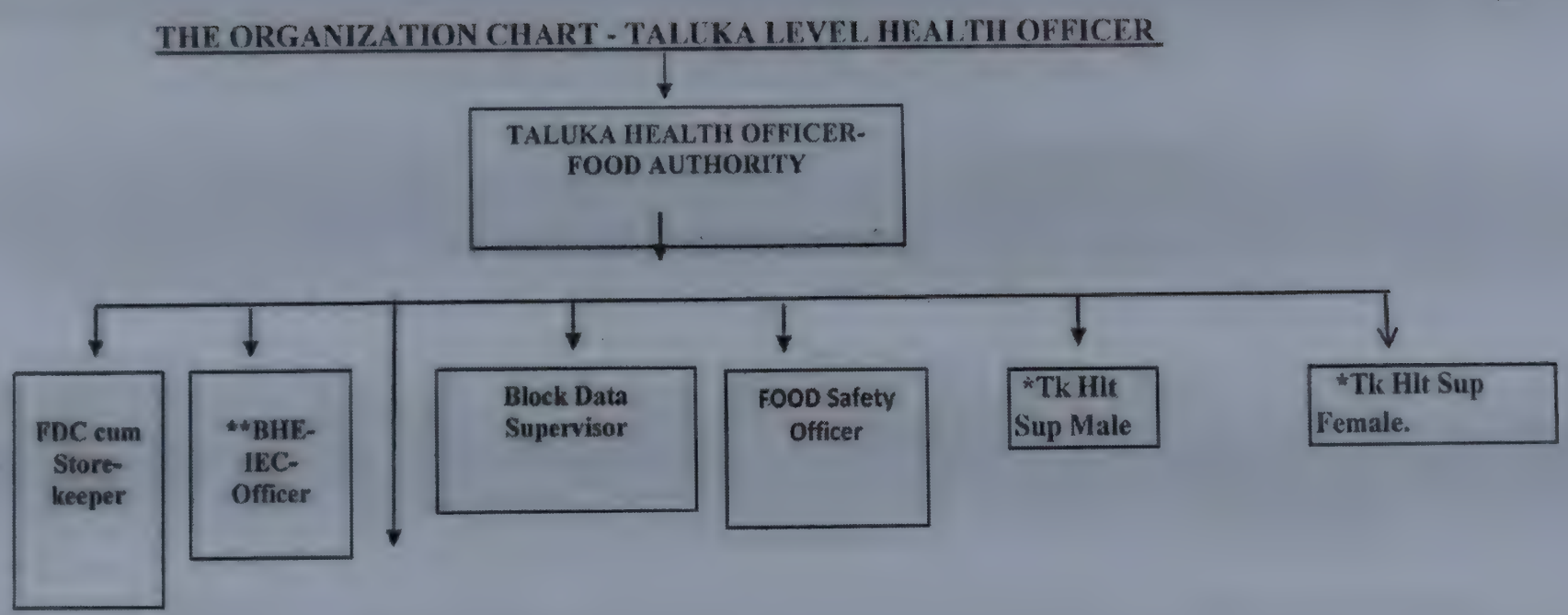
Note : RMO post is to be established at Tk Level Hospitals tolook into the daily day to day hospital functions,BMWMng, Social legislation, Diet, Stores Mng, Office functions, logistics,PRO.,etc.

*Casualty Medical Officers shall be a Sr Medical Officer,who has served at least 6 years of rural service

**Senior Specialists are Specialist with PG qualification,concerned speciality with >13yrs of service.

***Xray technicians who are exposed to >20exposures or >1 1/2 hrs of exposure time.

Annexure: 4 D contd.,

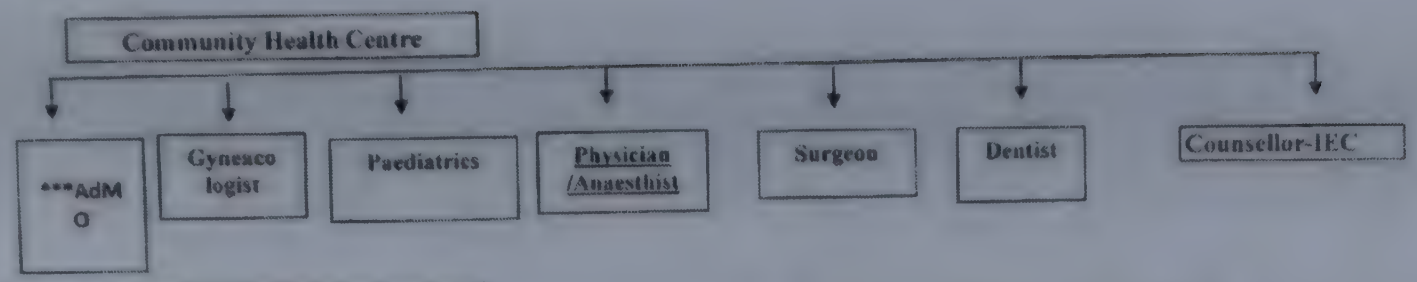


Note: * Creation of the post of SHAM & SHAF to be considered.

**BHE-IEC officer , designation to changed as Block IEC Officer.

Note: 1.Taluka Health Officer will be an MBBS qualified Health Officer trained in Public Health, with experience of atleast 6 years in **rural health service** as Medical Officer-PHC/Mobile Health Unit/Tribal Health Units. In case MO with Public Health qualification is not available then MO with PDC may be considered, giving preference to the seniority of civil list.

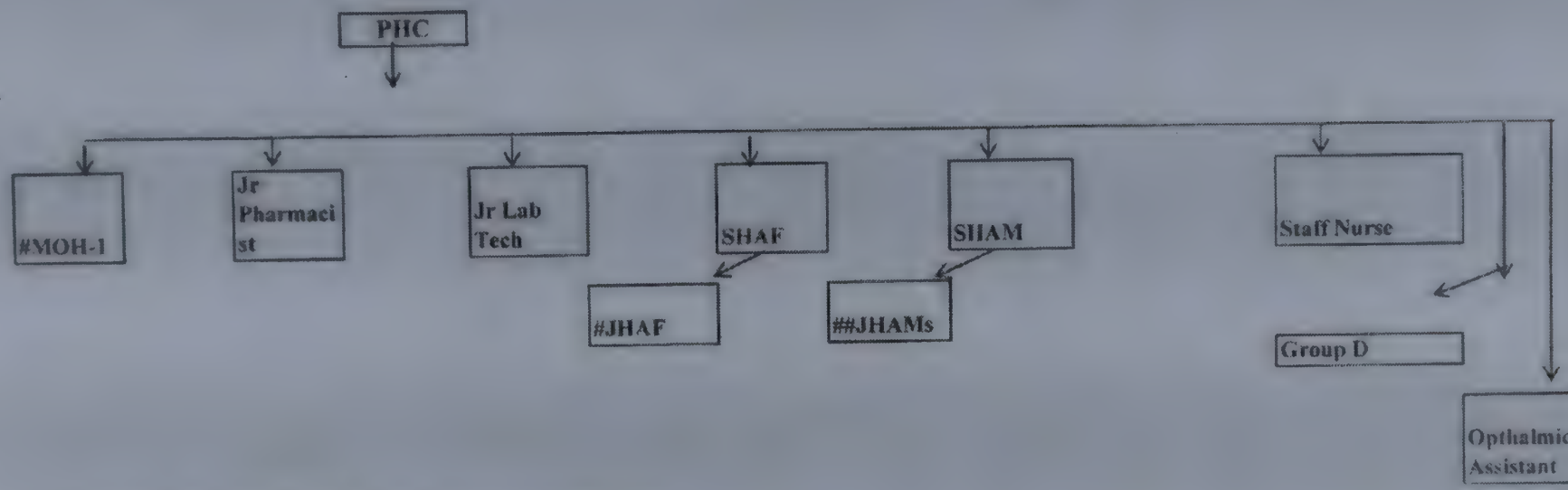
Annexure: 4 E



Note:*** Suitable nomenclature to be sourced

Counsellor-IEC from ICTC to be amalgamated from KSAPS, who shall counsell for other diseased also.

Note:# GDMO designation to be revised to Medical Officer of Health-Class 1



Note:# JHAF will be designated @ one per subcentre >5k population.

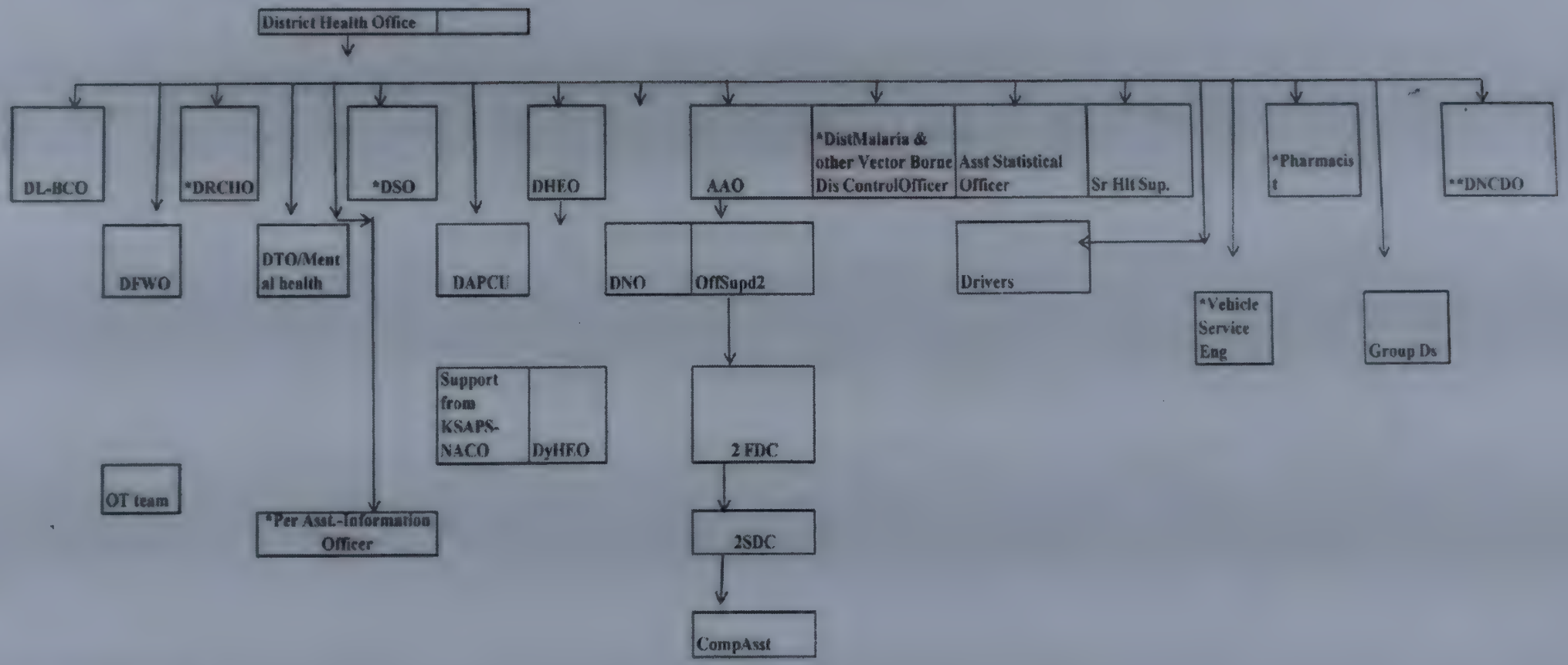
##, JHAM will be designated @ one per two centres.

Group D staff will be a minimum of 3, of whom one would be a Female.

Stafff Nurses recommended for 24/7 PHCs rendering Obstetric services is 3, which shall be amalgamated after NRHM initiative.

Jr Opthalmic Assisstant of CHC will give services to the catchment PHCs

Annexure: 4 E contd.,



Note:* posts to be revived.

DHO to be MBBS, with PG in Public Health, who has completed a **minimum of 18yrs of Service, of which min of 6yrs of rural health service completed, with seniority as per civil list.**

*Dist Level Programme Officers, shall be MBBS, with PG in Public Health, preferably, who has completed a minimum o f13 yrs of service, with min 6yrs of rural health service, with seniority as per civil list. The other three may be from the clinical stream.

**DNCDO District Non-communicable Disease Officer, shall look after the Disaster mngmt & Geriartrics.

DAPCU: District AIDS Prevention & Control Officer.

Note: All External Aided Projects shall be implemented in the District through one of the above Dist Programme Officer, depending on the "nature" of the aid provision.

References

1. Health & Family Welfare Task Force Report.
2. Gyana Ayoga Report.
3. Mysore Public Health Act.
4. Report of Independent Commission on Health in India by Voluntary Health Association of India. G O No.(OM)6 GRR 87, dt 20.6.80.
5. Karnataka Promotion of Public Health & Prevention of Diseases Bill 2010(Karnataka Act 2010)
6. Time bound Promotion of Asst. Surgeon cum Health Officer in the Dept. of Health, G O No.
7. Karnataka Medical Dept. Services (Recruitment Rules 1960 and amended up to 31.12.1991.
8. Karnataka Directorate, Dept. of Health and Family Welfare Services Recruitment Rules 1965 amended up to 31.7.1992.
9. Public Health Workforce in India- Career Pathways for Public Health Personnel by Dr KK Datta, 2009.
10. Hand book of Mysore State, Dept of Health, Bulletin no. 9, 1933.
11. Organogram of States of Maharashtra, Gujarat, Tamil Nadu and Andhra-Pradesh.
12. The Karnataka State Integrated Health Policy- 2001. Page no. 11-12. Proceedings of Cabinet. 2004

sochara

CHC Information Centre <clic@sochara.org>

wd: Reports

avi Narayan <chcravi@gmail.com>
o: CHC Information Centre <clic@sochara.org>

Fri, Sep 24, 2021 at 9:40 AM

Please printout chain of communication and the Halagi report and the other two attachments sent earlier by Dr Gururaj , especially Giridhars paper.
Thanks
Ravi

---------- Forwarded message ---------
From: **Gururaj Gopal** <epiguru1@gmail.com>
Date: Thu, Sep 23, 2021 at 7:28 PM
Subject: Re: Reports
To: Ravi Narayan <chcravi@gmail.com>

Dear Ravi,

Here is the report. Will talk to you soon. Regards
Dr. G. Gururaj, MD, FAMS
Chairman - Karnataka Health Vision group
Former Director and Dean
Senior Professor of Epidemiology,
Centre for Public Health
WHO CC for Injury Prevention and safety Promotion
National Institute of Mental Health & Neuro Sciences,
Bangalore – 560 029., India

On Thu, Sep 23, 2021 at 9:49 AM Ravi Narayan <chcravi@gmail.com> wrote:
> Thanks Guru! I look forward to the Halagi report - soft copy. Still trying to locate our archival copy (hard) as well.
> All the best
> Ravi
>
> On Thu, Sep 23, 2021 at 7:49 AM Gururaj Gopal <epiguru1@gmail.com> wrote:
> > PFA . will send the detailed report by night
> >
> > Regards
> >
> > Dr. G. Gururaj, MD, FAMS
> > Chairman - Karnataka Health Vision group
> > Former Director and Dean
> > Senior Professor of Epidemiology,
> > Centre for Public Health
> > WHO CC for Injury Prevention and safety Promotion
> > National Institute of Mental Health & Neuro Sciences,
> > Bangalore – 560 029., India

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